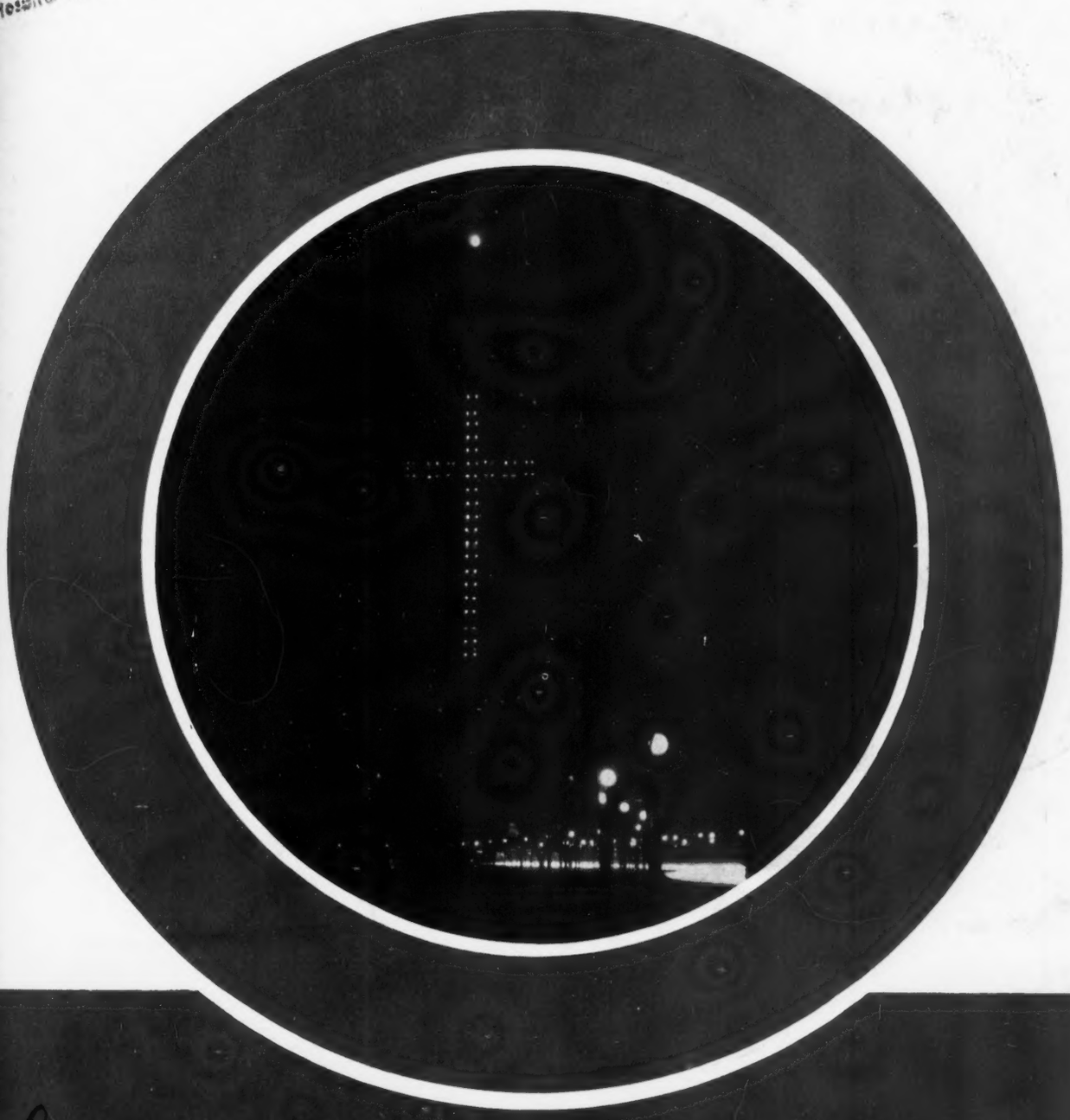
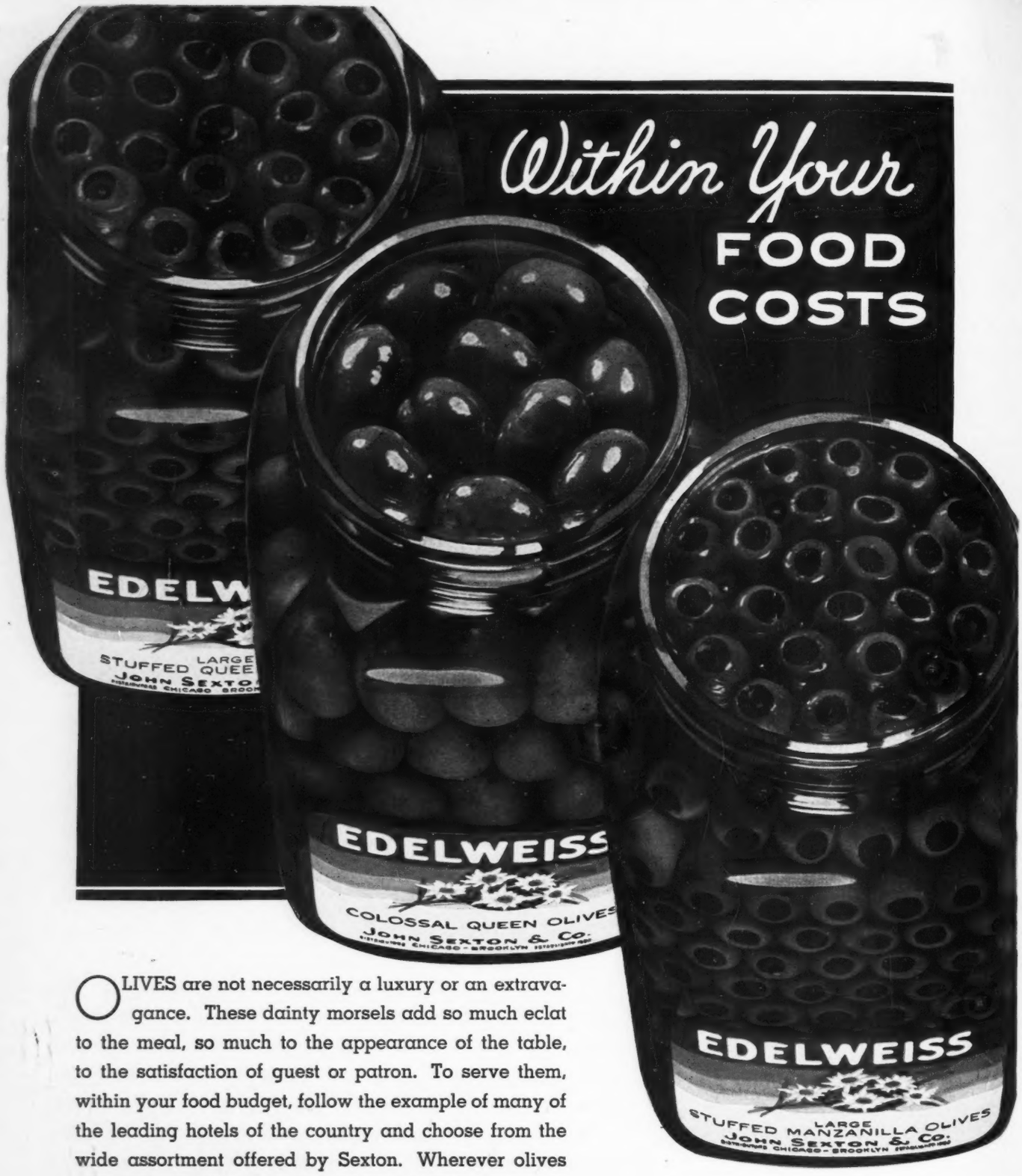


the MODERN HOSPITAL

VOLUME 49 DECEMBER 1937 NUMBER 6



OLIVES are not necessarily a luxury or an extravagance. These dainty morsels add so much eclat to the meal, so much to the appearance of the table, to the satisfaction of guest or patron. To serve them, within your food budget, follow the example of many of the leading hotels of the country and choose from the wide assortment offered by Sexton. Wherever olives are purchased in quantity Sexton olives have the acceptance. Sexton is one of the foremost importers of olives in America. By buying direct from an importer you save a profit.

Sexton Specials offer outstanding values in foods prepared exclusively for those who feed many people each day.

JOHN SEXTON & CO.

CHICAGO — Manufacturing Wholesale Grocers — BROOKLYN

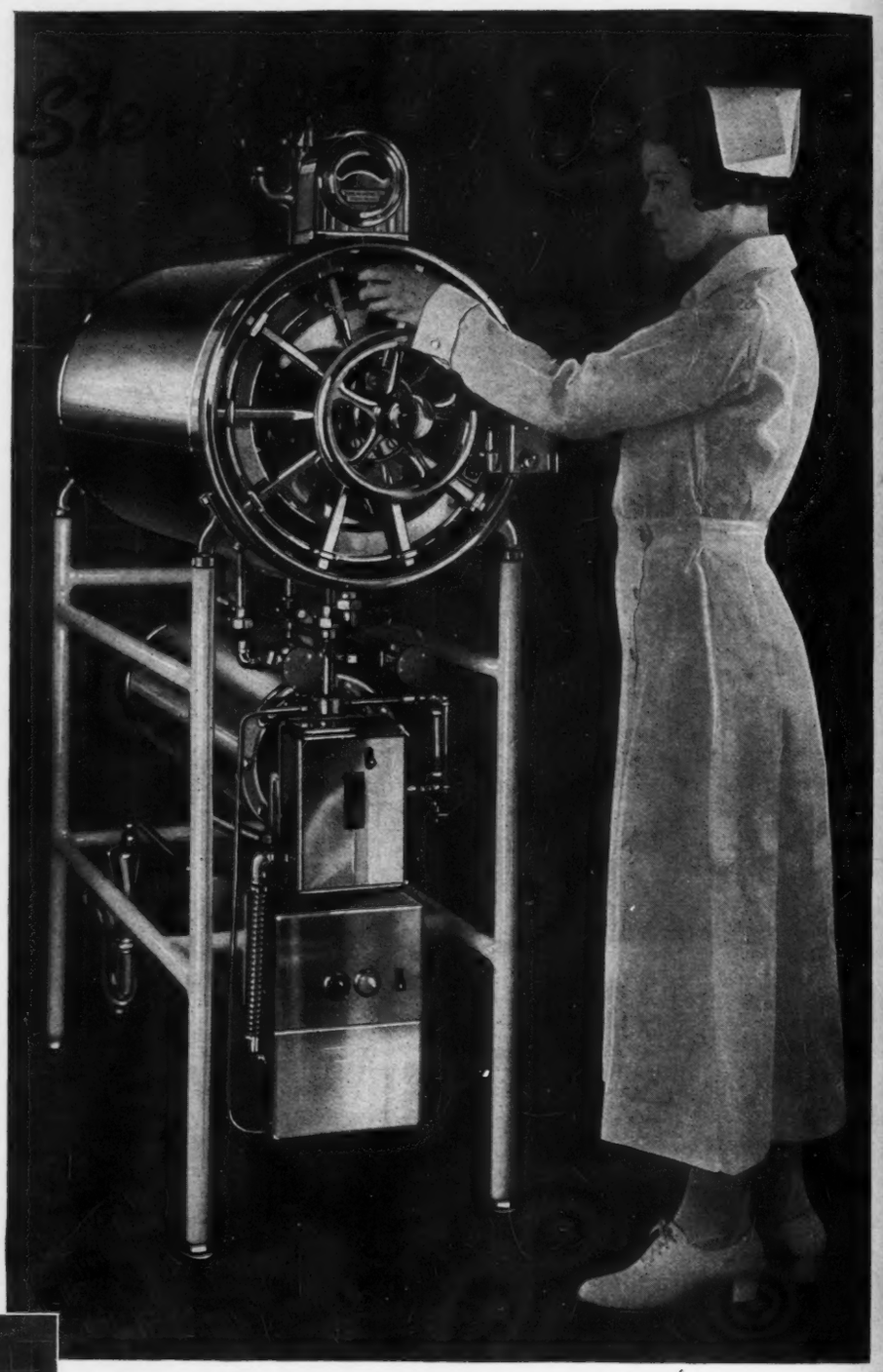
Established 1883

America's Largest Distributors of No. 10 Canned Foods

Positive
A FIRST ESSENTIAL

POSITIVE sterilization of surgical supplies is a first essential in the maintenance of aseptic techniques in the operating room. The efforts of a conscientious personnel in this respect are greatly aided by reliable equipment. Scanlan-Morris sterilizers, equipped with automatic devices that safeguard the sterilizing process, are extremely convenient to operate, dependably safe and durable.

Complete information relating to design, construction and important new developments is contained in the Scanlan-Morris catalog available to hospital executives and architects upon request. Our experienced engineers will be glad to receive a statement of your requirements and without obligation will prepare suggestions for the most efficient and economical installation of sterilizers to serve the specific needs.



● *Above:* Scanlan-Morris electric autoclave, with automatic air and condensation ejector, dial thermometer, automatic pressure control assembly adjustable for sterilization either at 15 lb. or 20 lb. pressures, and high efficiency rapid heating electric unit protected by automatic cutout.

● *Left:* Scanlan-Morris electric instrument sterilizer, with high efficiency rapid heating electric unit protected by automatic cutout. Equipped with "Vent-o-Stat" heat control when specified.

SCANLAN-MORRIS
Company

HOSPITAL FURNITURE---STERILIZING APPARATUS

MADISON, WISCONSIN, U. S. A.

OPERAY LABORATORIES
Surgical Lights

SCANLAN LABORATORIES, Inc.
Surgical Sutures

CONTENTS

For December, 1937

Just in Passing—

OUR front cover presents the south elevation of the Palmolive Building, Chicago, as it appeared on the eve of Dec. 24, 1936. From this building, topped by the Lindbergh aviation beacon, the personnel of The MODERN HOSPITAL sends greetings and good wishes to all hospital people throughout the world. Merry Christmas! Happy New Year!

You will find in this issue many Christmas ideas so that your patients and personnel may also make merry at Yuletide.

ALTHOUGH borne on the wings of an airship, the accompanying sketch of Nantucket Cottage

Hospital arrived a few hours too late to accompany Editor Sloan's account of his journey to this "far-away island hospital." (See pp. 58 to 62.) The drawing is so delightfully atmospheric that we were troubled about not being able to share it with you. Then we remembered this column and determined to make a berth for it here.

AS WE look forward to 1938, we can readily predict that it may be a year of testing. If

Published monthly by The Modern Hospital Publishing Co., Inc., 919 North Michigan, Chicago, and 101 Park Avenue, New York. Otho F. Ball, president; Raymond P. Sloan, vice president; Stanley R. Clague, secretary; J. G. Jarrett, treasurer. Yearly subscription, United States and Possessions and Canada, $3; foreign, $4. Single current copies, 35 cents; back copies, 50 cents to $1. Charter member Audit Bureau of Circulations.

Entered as second-class matter, October 1, 1918, at the Post Office at Chicago, Ill., under the act of March 3, 1879. Printed in U. S. A.

CONTENTS

so, the hospitals that are most alert and progressive will be the ones to survive. With that in mind we are planning an exceptionally fine series of issues. The January issue, for instance, will set you thinking along many lines, if only you will expose yourself to its challenge.

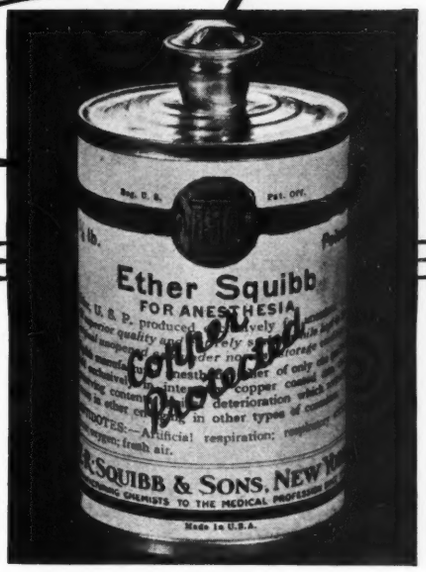
FIRST off, will be an article by Dr. Robert H. Kennedy pointing out the personnel methods, procedures and equipment needed to provide a competent fracture service in a hospital. This is a field of service open to nearly every hospital. The number of patients and the severity of their needs are increasing.

THEN John Mannix is going to tell why they are so enthusiastic about inclusive rates at the University Hospitals in Cleveland. His conclusions differ little from those of F. V. Altvater presented on page 47 of this issue. But the methods at Cleveland and, of course, the level of the rates are somewhat different from those in Durham.

When you have read both of these articles, if you are not deeply interested in the inclusive-rate plan, we miss our guess. Perhaps you have objections that don't seem to be met by the articles. If so, let's hear them.

GOVERNMENT hospitals, if the group for mental disease patients is included, contain about one-half of all the hospital beds in the United States. These institutions range from those that are mere pawns of politicians to some of the finest and best administered hospitals in the land. Next month we shall present the

Worthy OF TRUST



MANY VALUABLE ANESTHETIC AGENTS have been introduced since ether was first employed in surgery over 90 years ago, yet ether continues to be the safest, the most adaptable, and the most widely used.

Dr. E. R. Squibb pioneered in the production of a uniformly pure anesthetic ether. Today the production of Squibb Ether is mechanically controlled by unerring, sensitive automatic gauges. Squibb Ether is the only ether packaged in patented copper-lined containers to prevent the formation of undesirable toxic substances.

The fact that Squibb Ether is used in over 80 per cent of American hospitals and in millions of cases every year is an indication that surgeons and anesthetists have confidence in its purity, potency, and safety, and have found it to be worthy of trust.

FOR LITERATURE ADDRESS ANESTHETIC DEPT., E. R. SQUIBB & SONS, 745 FIFTH AVENUE, NEW YORK

SQUIBB ETHER

first of several articles dealing with the administration of government hospitals. Although aimed directly at the government institutions they will be of value to any hospital.

ANOTHER challenging article in our series on personnel management comes next month — this time from the pen of Clarence Hess of the Methodist Hospital, Indianapolis. In one of his fighting moods, Mr. Hess frankly takes issue with the whole program of providing maintenance to hospital personnel. Let's abolish it, he says, and have a happier, better paid and consequently more efficient working force. Perhaps he will lead a new crusade of abolitionists.

AND while we're improving hospital relations, let's give some added thought to the patient. Normally most of our patients probably awaken at home between 6:30 and 7:30 a.m. or even, perhaps, as late as 8 o'clock. But not in the hospital. Oh, no! Here, regardless of how restlessly he may have slept, the patient is firmly aroused in the cold light that precedes the dawn so that his face may be washed and his teeth cleaned. He can then toss on his cot for an hour or more before his breakfast arrives. Well, that's something else to abolish, and next month Mildred Constantine will tell why and how.

THERE are just too many good things on schedule to rhapsodize about each of them separately. Dr. Bernard Fantus will let us in on the secrets of the "blood bank," William A. Riley is going to describe a new orthopedic department, another article tells why we need plenty of room for the x-ray department, and Marie V. Wanzek will outline why ward clerks have proved so valuable at the University of Michigan Hospital.

FLASHES FROM THIS ISSUE:

"Insurance rates on hospitals without sprinkler systems are about two and one-half times the rate of those fully equipped with automatic sprinklers." *Page 81.*

"Reading in itself may easily be considered as one of the more severe visual tasks and when it is sustained for any length of time much energy is used." *Page 84.*

THE MODERN HOSPITAL

THE MODERN HOSPITAL PUBLISHING CO., INC.
OTHO F. BALL, M.D., *President*
919 NORTH MICHIGAN, CHICAGO, ILLINOIS

JOSEPH C. DOANE, M.D., *Editor*
RAYMOND P. SLOAN, *Associate Editor*
ALDEN B. MILLS, *Managing Editor*
MILDRED WHITCOMB, *Associate Managing Editor*

B-D YALE SYRINGES

Made of Resistance Glass

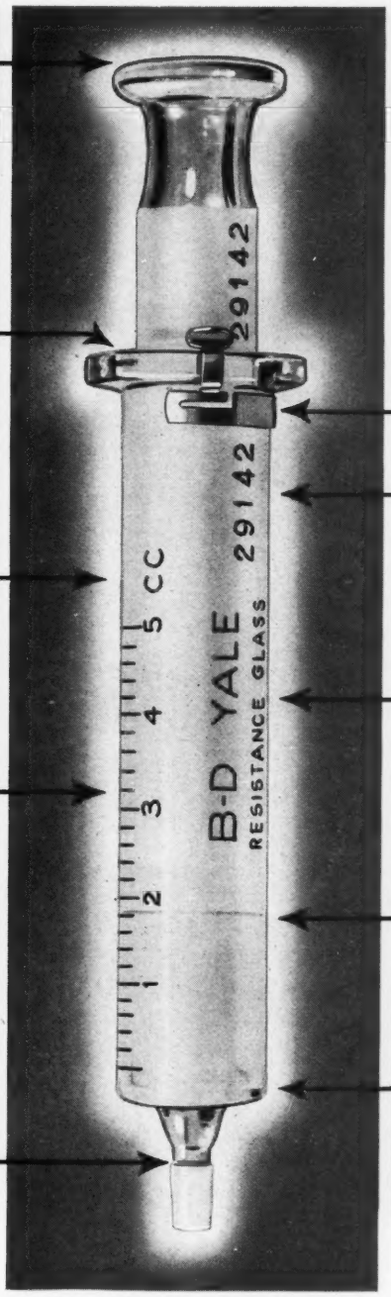
Slightly concave plunger thumb rest provides surer touch

Flared barrel opening receives plunger easily, reduces breakage

Barrel and plunger are individually fitted to each other

Scale pigment is permanently baked into barrel

Tip has glazed groove which eliminates score mark and greatly increases its strength



A dated certificate of accuracy comes with each B-D Yale Syringe

Simple, non-scraping plunger clip retains plunger

Plunger and barrel individually numbered

Careful annealing eliminates barrel strains, reduces breakage

Precision line on plunger aligns with scale for accurate dosage

Reinforced flared barrel end lessens breakage

B-D PRODUCTS
Made for the Profession

B-D Yale Syringes deliver the longest possible length of useful service, for the following reasons: Breakage at tip is reduced because the score mark of the grinding is eliminated and the tip has the full strength of unground glass... Breakage at the barrel base is reduced because the base is flared to eliminate an internal score mark.

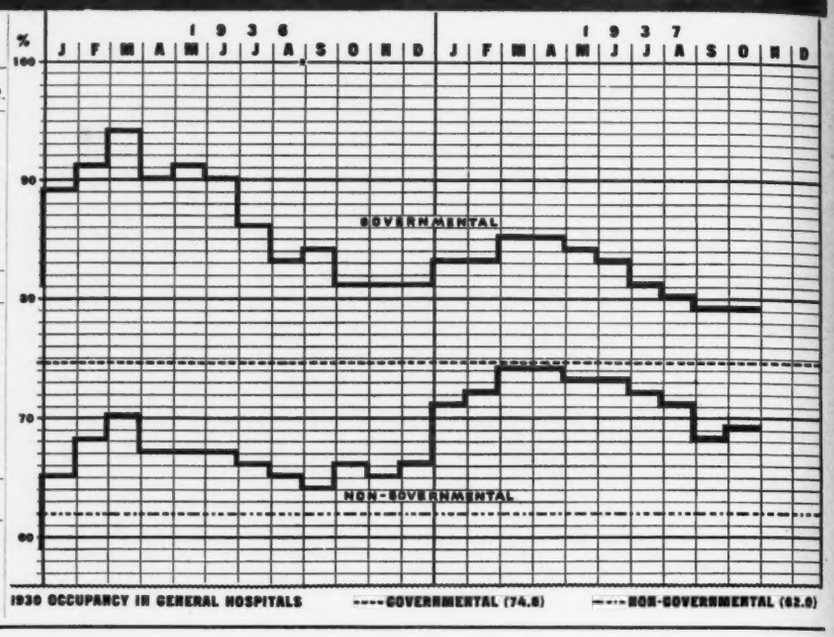
Every B-D Yale Syringe is tested by the Polariscope for stresses and strains, has a long, tight and smooth bearing surface and is treated to withstand more than 150 hours of continuous sterilization by the recommended method (clean, then sterilize with plunger home in barrel).

BECTON, DICKINSON & CO., RUTHERFORD, N. J.

HOSPITAL OCCUPANCY BAROMETER

Type and Place	Census Data, on Reporting Hospitals[1] Hosp.	Beds[2]	1937 Oct.	1937 Sept.	1936 Oct.	1936 Sept.
Government						
New York City	17	11,328	88*	88*	85	84
New Jersey	5	2,122	84*	84	81	78
Washington D. C.	2	1,596	65*	65	65	65
N. and S. Carolina	13	1,549	64	66	71	71
New Orleans	2	2,466	97	97	107	141
San Francisco	5	2,255	85	86	87	83
St. Paul	1	850	67	65	66	66
Chicago	1	3,419	83	81	83	81
Total[4]	46	25,585	79*	79*	81	84
Nongovernment						
New York City[3]	68	15,194	69*	69*	69	64
New Jersey	51	9,772	64*	64	64	61
Washington, D. C.	9	1,808	73*	73	74	70
N. and S. Carolina	108	6,812	65	66	67	66
New Orleans	7	1,146	67	68	65	64
San Francisco	16	3,129	76	75	73	71
St. Paul	8	884	62	65	54	61
Chicago	15	2,799	65	61	60	59
Cleveland	6	832	76	74	69	65
Total[4]	288	42,366	69*	68*	66	64

[1]Excluding hospitals for tuberculous and mental patients and institutional hospitals. Census data are for most recent month. [2]Including bassinets, usually. [3]General hospitals only. [4]Occupancy totals are unweighted averages. *Preliminary report. Complete occupancy figures for January, 1933, to October, 1936, are given on page 800 of the Fifteenth Hospital Yearbook.



Hospital Construction Continues to Spurt

The summer slump in occupancy of voluntary hospitals was brought to an end in October with a slight increase, which will probably be even larger when all reports are received. On the basis of the preliminary figures this past October is three points higher than October of 1936.

Highest occupancy this month was reported from the six voluntary hospitals of Cleveland, their figure reaching 76 per cent. The lowest report this month was from St. Paul, where occupancy in October had fallen to 62 per cent. The eight reporting hospitals in St. Paul seem to have wider fluctuations in occupancy than are reported from any of the other cities or states.

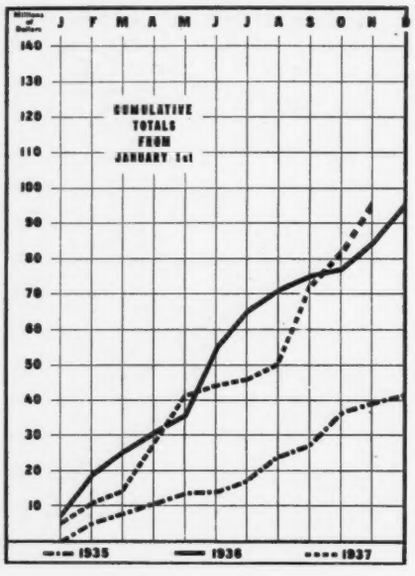
Government hospitals continued with approximately the same load as they had during the preceding three months. New Orleans continued to have the highest occupancy, 97 per cent, while St. Paul, Chicago, the Carolinas and Washington, D. C., are at the other end of the scale.

Hospital construction projects were announced with increasing frequency during November. It now appears that 1937 will show a somewhat larger total spent for hospital construction than 1936. These figures have more than doubled since 1935 and 1934.

During the four weeks' period from October 25 to November 22 there were 71 building projects reported. Costs could be obtained on 67 of these. The total money involved is $12,932,000.

There were only eight new hospitals, seven of which reported costs of $800,000. Practically all of the money went into 54 additions to existing hospitals. Fifty-one of these reported costs which came to a total of $11,140,000. There were six alteration projects to cost $930,000 and three nurses' homes to cost $60,000.

HOSPITAL CONSTRUCTION



General wholesale prices, according to the index of the *New York Journal of Commerce*, continued their downward course during the last of October and the first half of November. The general index fell from 86.1 on October 18 to 82.1 on November 15. All of the different items usually mentioned on this page dropped during this period. Grain prices went from 80.1 to 72.7; food prices from 86.7 to 75.4, and textiles dropped in price from 62.0 to 57.9. Fuel and building materials did not plummet so rapidly but even here the trend was downward, fuel going from 90.1 to 88.7 and building materials from 99.3 to 98.6. (All of the above index figures are based on the years 1927 to 1929 as 100.) The price index of drugs and fine chemicals, as compiled by the *Oil, Paint and Drug Reporter*, advanced slightly. Employment in manufacturing industries, which has been falling during the autumn, was, on November 13, still ahead of the amount one year earlier, according to a special telegraphic inquiry conducted by the National Industrial Conference Board. However the decline in employment has been less than the decline in manufacturing output, indicating that hours of work have been reduced.

Kern
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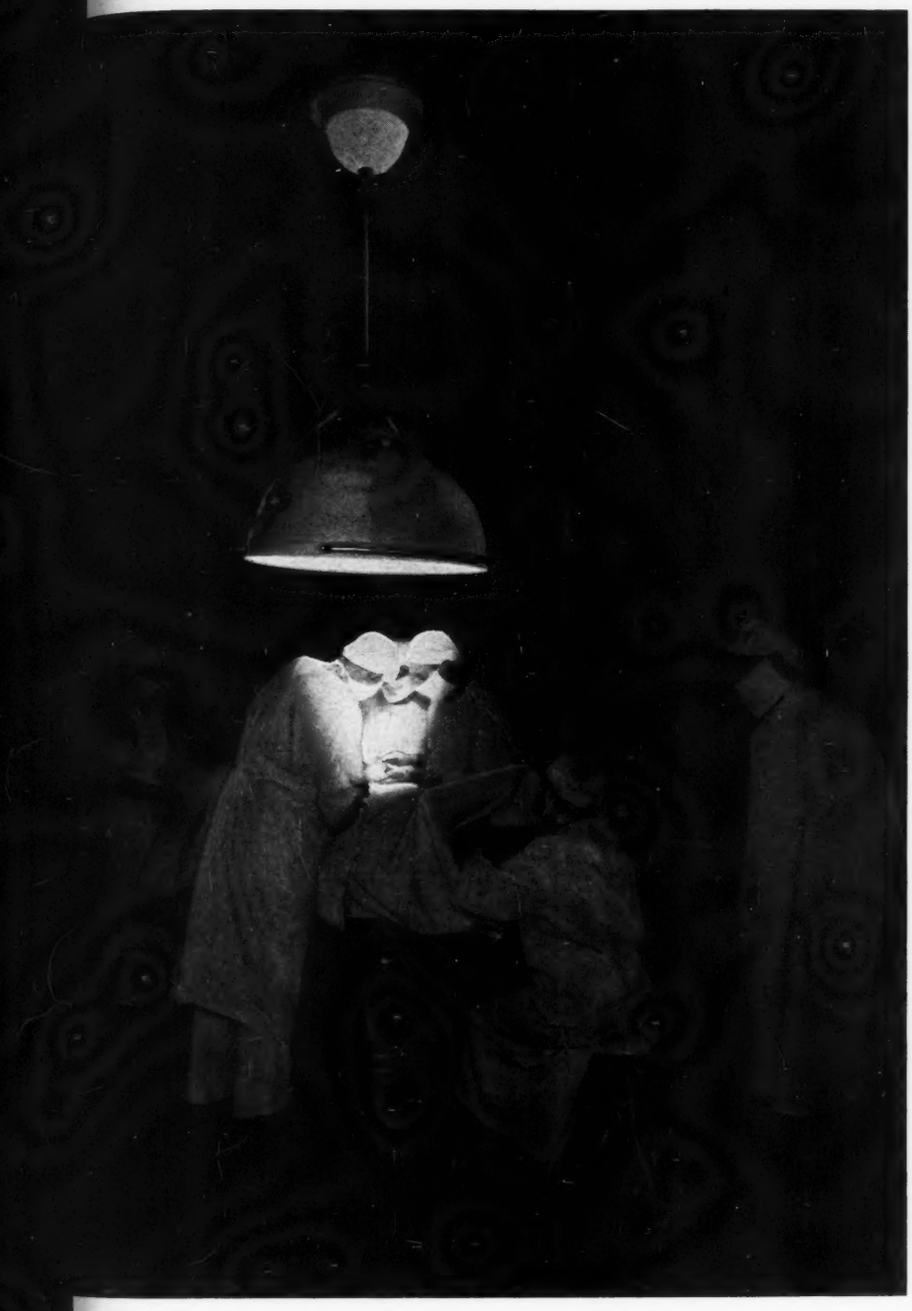
MODERN *Surgical Illumination*



AMERICAN LUMINAIRE *Surgical Light*

CLOSE analysis of the problems involved in surgical illumination clearly indicates that—the ultimate is approached when design and construction cater altogether to the "comfort of the surgeon," to the end that he is enabled to do his delicate and exacting work, without being conscious either of the illumination or its source.

Further analysis from this angle defines that the light shall be of the right intensity (foot candles)—not too great nor too weak—so that there is clear visibility; that the light shall be of a color quality (color temperature—degrees Kelvin) that permits clear discrimination of objects in their natural color; that the light be so distributed that shadows are reduced to a minimum (light projection); and finally that these specifications be met—developing a negligible quantity of heat in the surgical area (a detail of light filtration).

★ ★

SEND FOR AMERICAN LUMINAIRE SURGICAL LIGHT—BULLETIN L

A Few Prominent Users

Kern County General Hospital (2 units)	Bakersfield, Calif.
Samuel Merritt Hospital (2 units)	Oakland, Calif.
St. Joseph's Hospital (5 units)	Denver, Colo.
Pensacola Hospital (2 units)	Pensacola, Florida
American Hospital (2 units)	Chicago, Ill.
Beth Israel Hospital	Boston, Mass.
St. Vincent's Hospital (3 units)	Worcester, Mass.
St. Joseph's Mercy Hospital (4 units)	Detroit, Mich.
Midway Hospital (8 units)	St. Paul, Minn.
Mounds Park Sanitarium (6 units)	St. Paul, Minn.
Hudson County T. B. Hospital	Jersey City, N. J.
Carrie Tingley Hospital (2 units)	Hot Springs, N. M.
Crile Clinic (2 units)	Cleveland, Ohio
Temple University Hospital (3 units)	Philadelphia, Pa.
St. Francis Hospital	Pittsburgh, Pa.
Baptist Memorial Hospital (6 units)	Memphis, Tenn.
Southwestern General Hospital (4 units)	El Paso, Texas
Hermann Hospital (4 units)	Houston, Texas
Jefferson Davis Hospital (27 units)	Houston, Texas
Tacoma General Hospital	Tacoma, Wash.

AMERICAN STERILIZER COMPANY

ERIE, PENNSYLVANIA

Sales Offices in New York, Chicago, Boston, St. Louis
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AMERICAN COLLEGE OF SURGEONS

INDEX OF ADVERTISERS

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Continued on page 12

"I'm leaving! I can't afford a hospital that uses such super-swell towels!"

"Wait! See the CANNON label—Best towels! Best values!"

POOR PATIENT! He thought these soft, expensive-looking towels must be a luxury item that would raise his bill to fever pitch! He didn't know that the Cannon policy enables his hospital to include the extra service of Cannon towels at no extra charge!

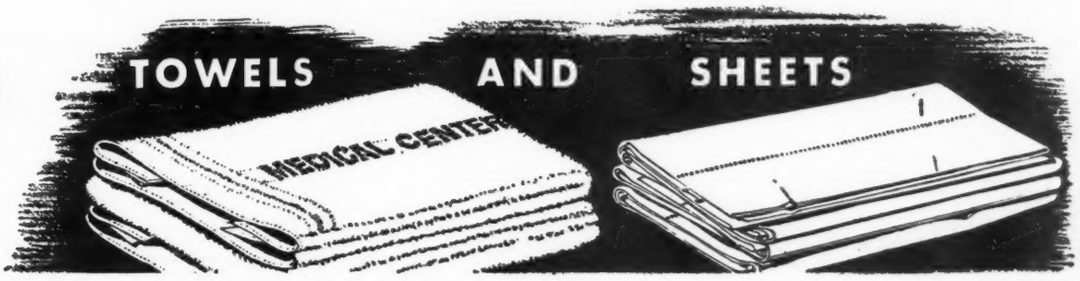
What is the Cannon policy? Simply better quality at regular cost, or regular quality at less cost. How can Cannon afford such a policy? Because of their bigger volume, their longer experience, their better equipment, and their higher standards of production.

The purchasing agent approves the Cannon policy because it saves money for his institution; doctors, interns, nurses approve because they have learned that they can *depend* on Cannon towels; patients applaud because they appreciate the comfort and gentle treatment that Cannon towels assure them.

The Cannon line is complete, ready to meet every hospital requirement, including price. Bath towels, cotton and union huck towels, bath mats, wash cloths, glass towels, and kitchen towels, with the added features of name-weaving and reinforced hemmed selvages—Cannon has them all. . . . Cannon Mills, Inc., 70 Worth Street, New York City. World's largest producers and largest national advertisers of household textiles.

• *Cannon sheets have as many fine points as Cannon towels. There's a Cannon sheet in each price class and for every purpose. Cannon Muslin, Cannon Utility Percale, and Cannon Fine Quality Percale. Each brings you more for your money.*

CANNON



INDEX OF ADVERTISERS

Continued from page 10

This ★ symbol preceding firm name signifies that a Catalog or other Advertisement will be found in The HOSPITAL YEARBOOK.

IN COLUMBIA-PRESBYTERIAN MEDICAL CENTER

Rubber Tile Floors INSURE BEAUTY, COMFORT AND QUIET

FLOORS of Armstrong-Stedman Reinforced Rubber Tile are used in Columbia-Presbyterian Medical Center because they offer a *combination* of advantages that makes them highly desirable for hospital service:

QUIET—The resilience of rubber tends to cushion footsteps. This means greater comfort for patients, higher efficiency from employees.

ECONOMICAL—Maintenance is easy and inexpensive. Daily dusting and occasional washing and waxing keep these floors sanitary and preserve their rich glossy finish. Spilled liquids wipe up without staining.

CHEERFUL—Forty colors in marble, paisley, and two-tone effects can be combined into appropriate designs for every style of decoration. The colors run through the full thickness of each tile. Traffic and scraping furniture do not wear them off.

DURABLE—Armstrong-Stedman Reinforced Rubber Tile is made with a strong interwoven reinforcement that makes the tile more resistant to denting and wear. This invisible reinforcing also prevents buckling and crazing when subfloors contract and expand.

Reinforced rubber tile, which brings you these extra advantages at no extra cost, is exclusive with Armstrong, the maker of Armstrong's Linoleum, Linotile, Accotile, and Cork Tile. Write today for a color-illustrated copy of "New Beauty and Comfort in Floors." Armstrong Cork Products Company, Building Materials Division, 1210 State Street, Lancaster, Pennsylvania.

Colorful floors of reinforced rubber tile provide long-lasting beauty and quiet in this corridor at Columbia-Presbyterian Medical Center, New York City.

~ ~ ~

ARMSTRONG'S *Linoleum* *and* RESILIENT TILE FLOORS

LINOTILE · ACCOTILE · CORK TILE · RUBBER TILE · LINOWALL · ACOUSTICAL CEILINGS

"GETS DOCTORS QUICKLY"

—says Baltimore's Mercy Hospital

The Mercy Hospital in Baltimore, Maryland, reports that its Western Electric Program Sound System has increased the efficiency of its doctors' paging service—saving time when it counts most.

Similar systems are used in many hospitals not only for doctors' paging but also for supplying cheery entertainment to convalescents.

When you modernize your hospital with sound distributing equipment, be sure the quality is right—use Western Electric. Made by the leaders in sound-transmission apparatus, it assures highest quality reproduction and trouble-free performance.

For full details, free survey and estimates send the coupon below.

Western Electric
PROGRAM SOUND SYSTEMS
Distributed by GRAYBAR Electric Co.
In Canada: Northern Electric Co., Ltd.

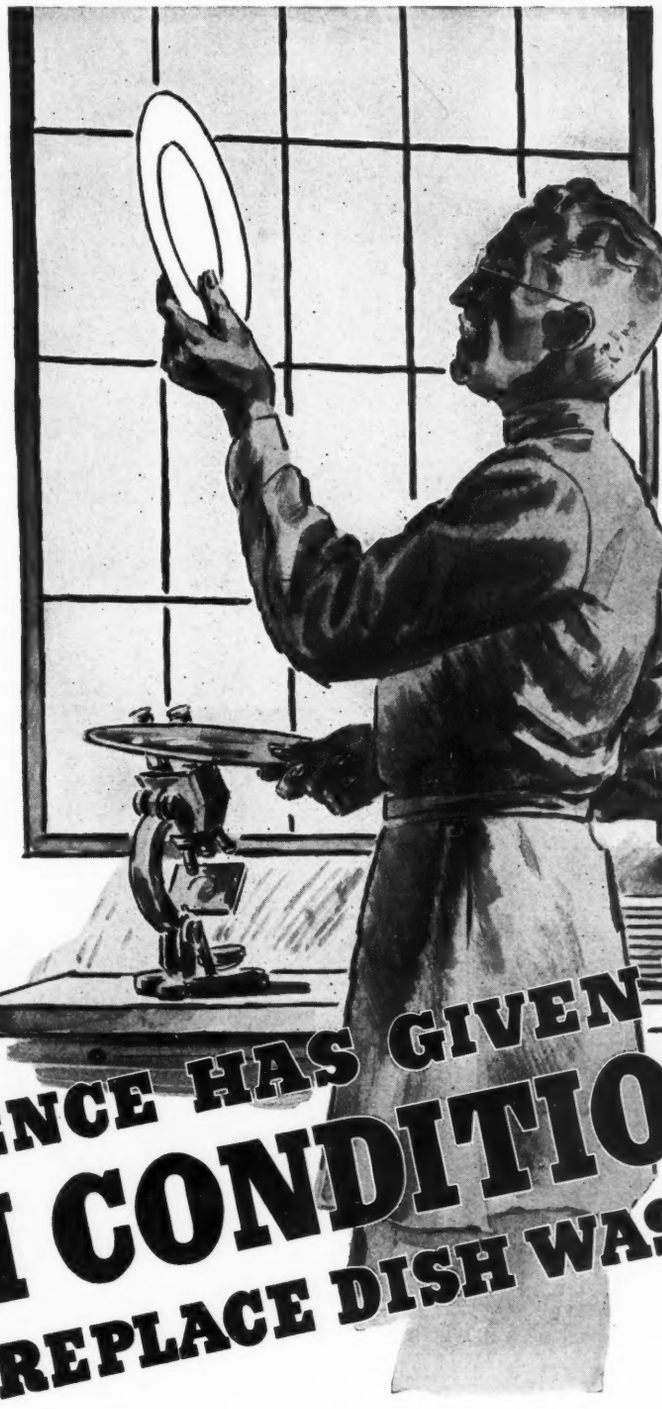
GRAYBAR ELECTRIC CO., Graybar Building, New York

Gentlemen: I want to hear more about Western Electric sound distributing equipment. Please have one of your men call on me. MH-12-37

Name .....

Hospital .....

City ..... *State* .....



SCIENCE HAS GIVEN YOU DISH CONDITIONING TO REPLACE DISH WASHING

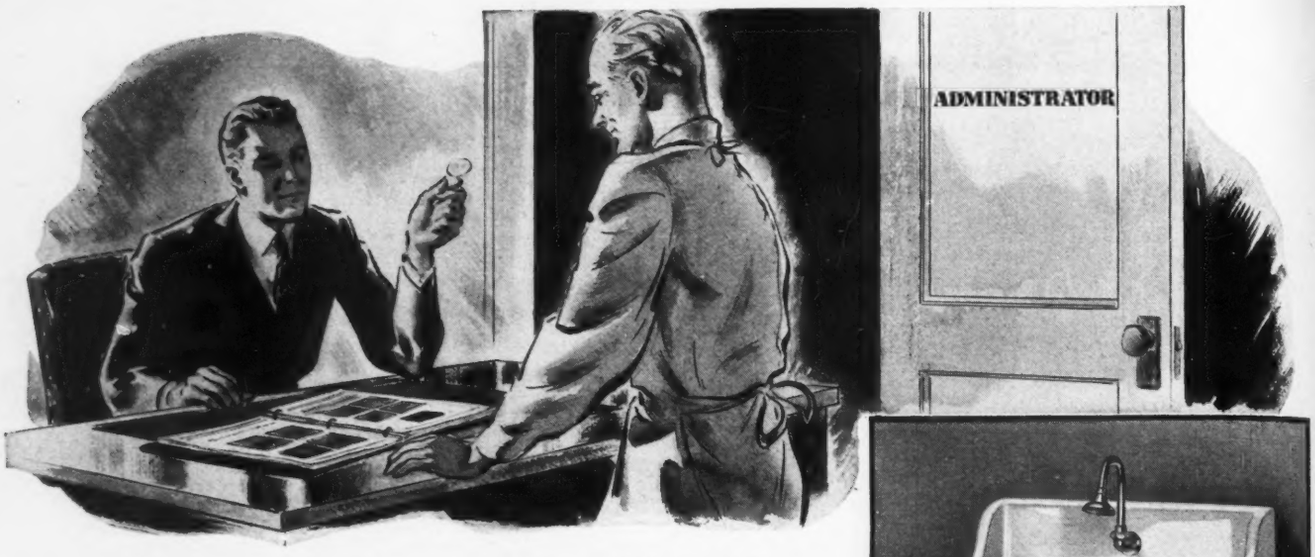
When a washed dish bears no visible trace of food or dirt, is it necessarily *clean and healthful?* ABSOLUTELY NO! Science proves that the more often a dish is used and washed *the more dangerous to health it becomes* if invisible film is not removed!

Ordinary dishwashing *does not remove* the film that carries sickness and disease. DISH-CONDITIONING DOES. A *conditioned* dish is a healthful dish—the only kind you can afford to set before your patrons! • *Write today for the story of "Dish-Conditioning vs. Dishwashing".*

calgonite

CALGON, INC.
300 ROSS STREET
PITTSBURGH, PA.

MAKES DISH CONDITIONING POSSIBLE

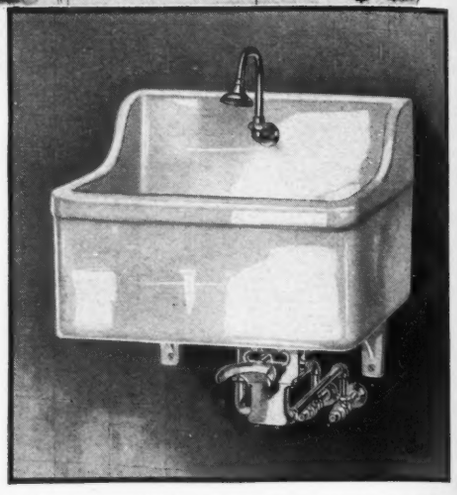


ADMINISTRATORS AND SURGEONS *agree on* CRANE QUALITY

● Administrators know that in selecting hospital equipment there can be no compromise with quality. That is why they look to Crane for their needs in plumbing fixtures. Crane hospital equipment embodies every feature that is essential to satisfactory performance. Crane design is backed by the best of surgical opinion—careful research and long study of modern hospital practice. Crane manufacture employs only proved materials that assure long life and workmanship that assures trouble-free service. Administrators agree that Crane quality means safety of investment.

To the surgeon, too, Crane quality has great significance. On wash-up sink or infant's bath, the name Crane is his guarantee of the ultimate development in the promotion of sanitation and asepsis. That is why surgeons agree that Crane quality means greater safety to patients.

The Crane Catalog of Hospital Equipment—fully approved by the American College of Surgeons—is a trustworthy guide to safety and satisfaction if you are remodeling or building a hospital. Write for *your* copy. We invite you to ask about the Crane Budget Plan for hospital modernization.



The Crane Mayo Wash-up Sink is correctly designed for the convenience of the surgeon. Has a gooseneck spray and knee-action mixing valve. Made of vitreous china—easy to keep clean.

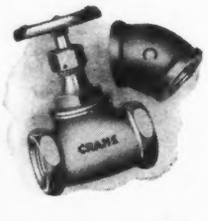
The Crane *Cornell* Service Sink minimizes danger of contact with polluted waste water. Used in obstetrical department, operating and autopsy rooms, and laboratory. Made of vitreous china. Has positive and vigorous flushing action. Trapway can pass three-inch solid ball. Fittings are sturdily built.

CRANE

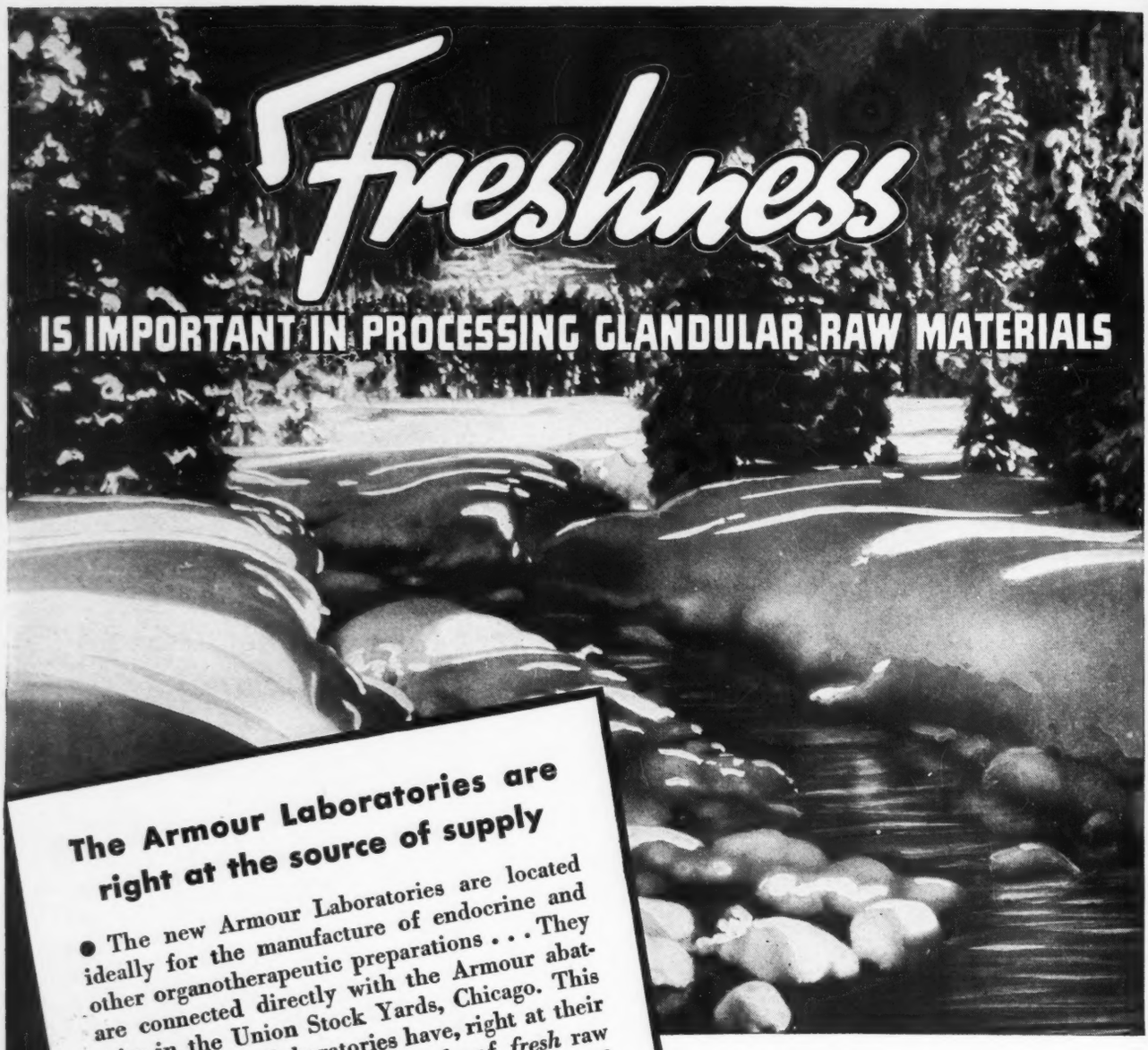
CRANE CO., GENERAL OFFICES: 836 SOUTH MICHIGAN AVENUE, CHICAGO

Branches and Sales Offices in One Hundred and Sixty Cities

VALVES, FITTINGS, FABRICATED PIPE, PUMPS, PLUMBING AND HEATING MATERIAL



Crane has the world's largest line of valves and fittings for all types of service — everywhere. Crane-Equip *throughout* for satisfaction.



The Armour Laboratories are right at the source of supply

● The new Armour Laboratories are located ideally for the manufacture of endocrine and other organotherapeutic preparations . . . They are connected directly with the Armour abattoirs in the Union Stock Yards, Chicago. This means that the Laboratories have, right at their doors, the world's largest supply of *fresh* raw materials. Processing of this material is started quickly, before the glands have lost their animal heat.

And freshness of raw materials when processing starts is important, because drying and deterioration of the glandular tissue set in very rapidly. This deterioration may have the effect of reducing the potency of a preparation. The freshness of Armour's raw materials protects you from this danger. This is one of the reasons why Armour products are uniform. You can rely on them...specify Armour in your prescriptions.

THE ARMOUR LABORATORIES

Headquarters for Medicinals of Animal Origin

ARMOUR AND COMPANY, UNION STOCK YARDS, CHICAGO

Some Armour Standardization Methods

ARMOUR THYROID
has been standardized on the *Thyroxine* Iodine Content.

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has been standardized on the *Guinea Pig Uterus* for its Oxytocic Potency.

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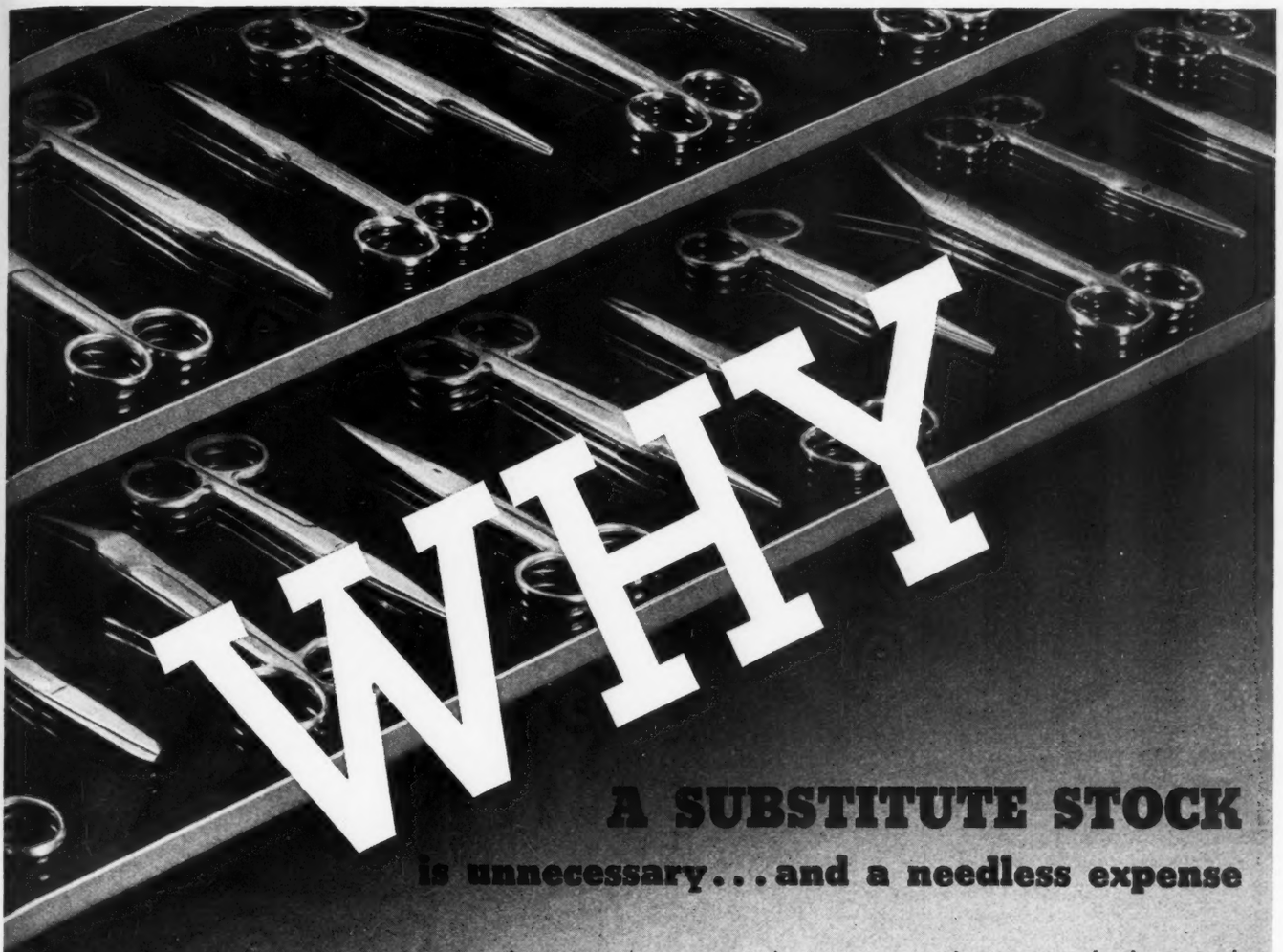
When the success of a plan depends upon its perfect execution there must be strict co-ordination between the individuals involved. No program of treatment can relieve the incidence of constipation unless the patient is willing to co-ordinate his efforts with those of the physician. That is why so many doctors prescribe Petrolagar for their patients. Its pleasant taste and gentle consistent action are acceptable to the patient as well as to the physician . . . . Five types of Petrolagar provide a choice of medication to suit the individual case . . . . Samples on request. Petrolagar Laboratories, Inc. • Chicago, Ill.

Petrolagar is a mechanical emulsion of pure liquid petrolatum (65% by volume) and agar-agar. Accepted by the Council on Pharmacy and Chemistry of the American Medical Association for the treatment of constipation.

Petrolagar

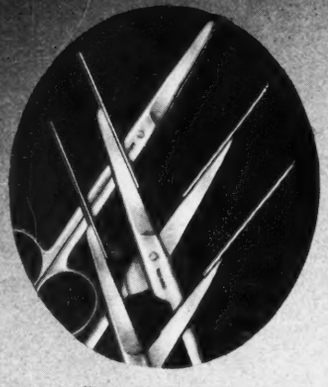


WHY

A SUBSTITUTE STOCK

is unnecessary . . . and a needless expense

In purchasing conventional type surgical scissors, the hospital purchasing agent is influenced by two factors in gauging the quantity of the purchase . . . the possibility of an instrument becoming unserviceable at a critical moment, and the fact that dull scissors must be sent away to be reground. To meet these contingencies adequate reserve pairs are kept on hand at all times. In summing up the cost of maintaining a substitute stock . . . the cost and inconvenience of constant regrinding . . . the cost of replacements made necessary by regrinding beyond the serviceable point, purchasing agents welcome the advantages of . . .



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Available in straight operating, straight and offset dissecting patterns, from $3.35 to $4.85 a pr. Scissor edges all sizes (3 pr. to pkg.) per pkg., 60c.

The perpetual sharpness of a single pair of B-P renewable edge scissors can readily be maintained by the instant replacement of dulled edges with new keen ones . . . at half the normal cost of regrinding. Expenditures for scissors maintenance are thus confined to actual requirements.

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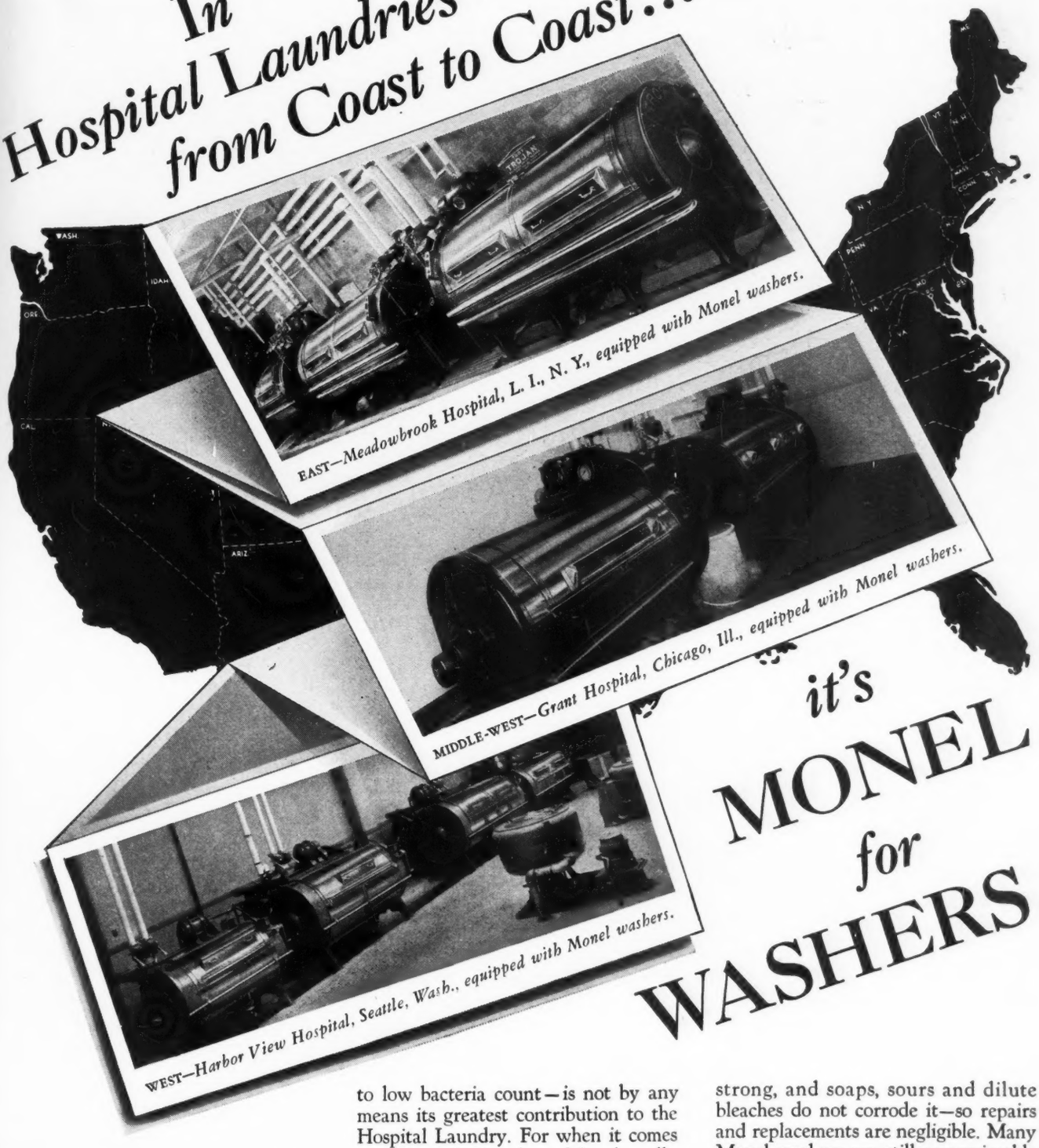

it's MONEL for WASHERS

Typical Hospital Laundries in the East, Middle-West and Western states turn to the modern washer metal, Monel

FROM Atlantic to Pacific, Gulf to Great Lakes, hospitals having the good fortune to operate laundries of their own are experiencing the *better* fortune of operating Monel* washers.

Examine closely the installations pictured above—have you ever seen a cleaner looking set-up in *any* laundry? And Monel's unique cleanliness—aid to low bacteria count—is not by any means its greatest contribution to the Hospital Laundry. For when it comes to costs—that's where Monel really shines.

If you want to cut operating costs to the bone—and what hospital doesn't—check these proved places for saving with Monel washers:

SPACE: Monel washers have *twice* the capacity of old-style machines—so handle the same load in half the space.

OPERATING COST: Monel washers have twice as much open area and a smaller clearance between cylinder and shell—so use *less* water, *less* steam, *less* soap and supplies.

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Equip with Monel washers and you say goodbye to rust, rough spots, and snagged and torn garments. You save labor, save time, save money. For further information on Monel washers—also extractors, trucks, tables, pails and starching equipment, write:

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*Monel is a registered trade-mark applied to an alloy containing approximately two-thirds Nickel and one-third copper. This alloy is mined, smelted, refined, rolled and marketed solely by International Nickel.

MOVIE STARS AND SPORTS LOVERS

ski at Sun Valley

Superb sun—sparkling snow—outdoor swimming even in zero weather! You go swooping down mountains, and bask in the sunshine. That's the life at Sun Valley, Idaho!

and sleep on PEQUOTS

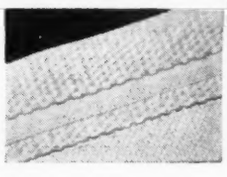
And there's luxurious comfort, too! You play hard all day; and at night you sink into one of the Lodge's deep beds, between smooth, soft Pequot sheets—and sleep like a log!

WHEN SHEETS were selected for Sun Valley Lodge, Pequots were the natural choice. Their rich, smooth texture suggests the luxury which wealthy Lodge guests expect. Yet Pequots are not expensive. And they wear amazingly!

The *soft strength* which put Pequots in Sun Valley Lodge... has also made them the most popular brand of sheets in America! *Soft strength* makes Pequots stay fresh on the bed longer... come from the laundry firm and white... and 'way outlive sheets that offer merely surface smoothness. It pays to SPECIFY Pequots in buying! Pequot Mills, Salem, Mass. General Sales Offices: 21 E. 26th St., New York City; Boston, Philadelphia, Chicago, San Francisco.

Size-showing tabs (left). *Visible in storage, because they stick out away from the hem. They save time and labor.*

Double tape selvage (right). *Extra strength and extra wear are assured by this twin Pequot reinforcement.*



PEQUOT
SHEETS AND PILLOW CASES

The sign of the Pequot! Look for this famous shield label when you buy!

PEQUOT

Sheets and Pillow Cases

COLDS usually run their course...

...but the patient appreciates symptomatic relief of the nasal congestion.

An effective way to promote free breathing and relieve the "stuffed-up" feeling in colds, rhinitis and sinusitis, is the instillation of

NEO-SYNEPHRIN
HYDROCHLORIDE
(levo-meta-methylaminoethanolphenol hydrochloride)

EMULSION

When Neo-Synephrin Emulsion is applied topically to the nasal mucosa, the low surface tension insures thorough and even spreading over the mucous membrane. The vasoconstrictive action is accomplished without sting and, in the dosage recommended, Neo-Synephrin does not usually produce "nervousness" or insomnia.

DOSAGE FORMS OF NEO-SYNEPHRIN HYDROCHLORIDE:

EMULSION— ¼% (1-oz. bottle with dropper)

SOLUTION— ¼% for dropper or spray, 1% for resistant cases } (1-oz. bottle)

JELLY— ½% (in collapsible tubes with applicator)

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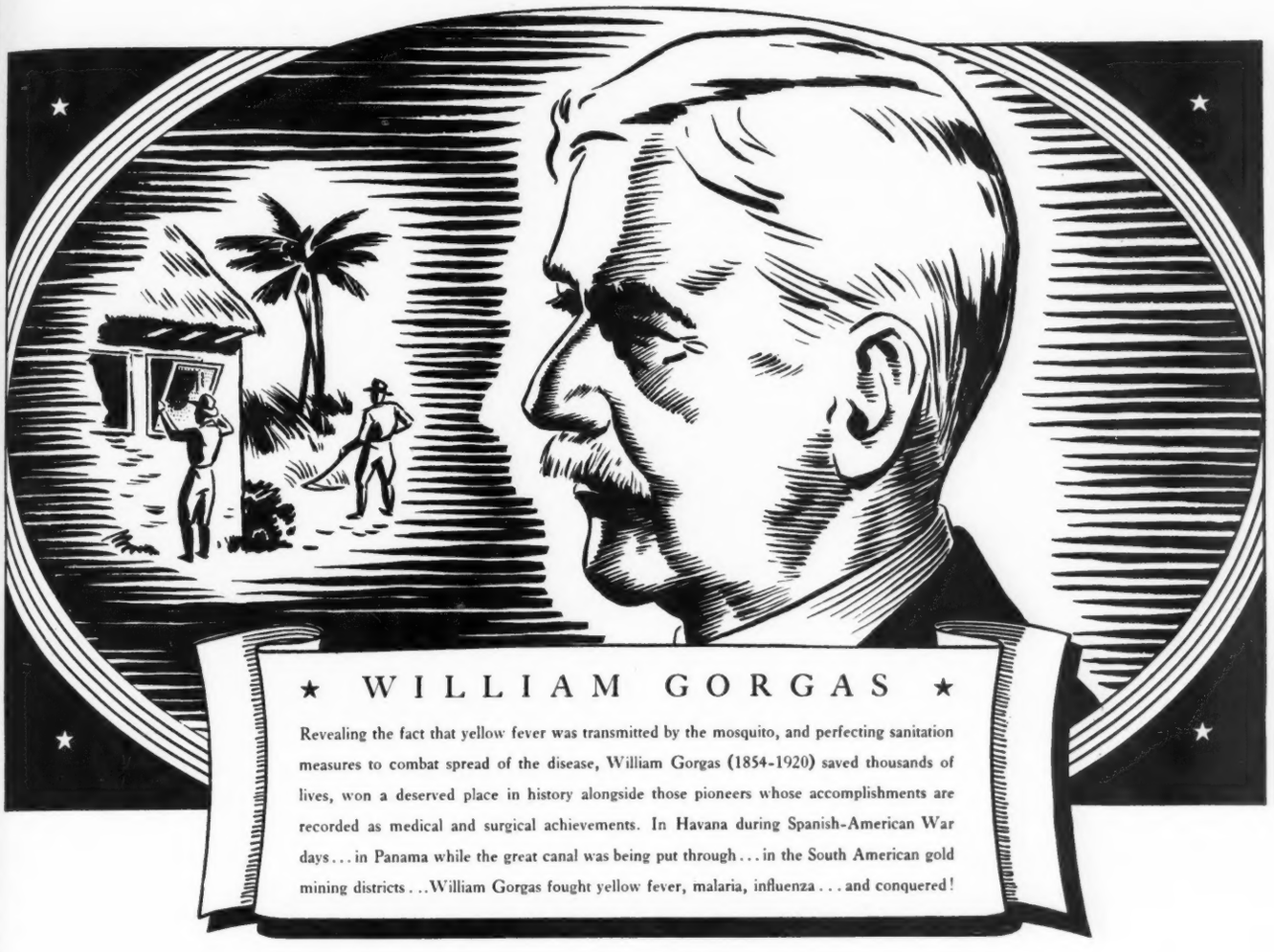
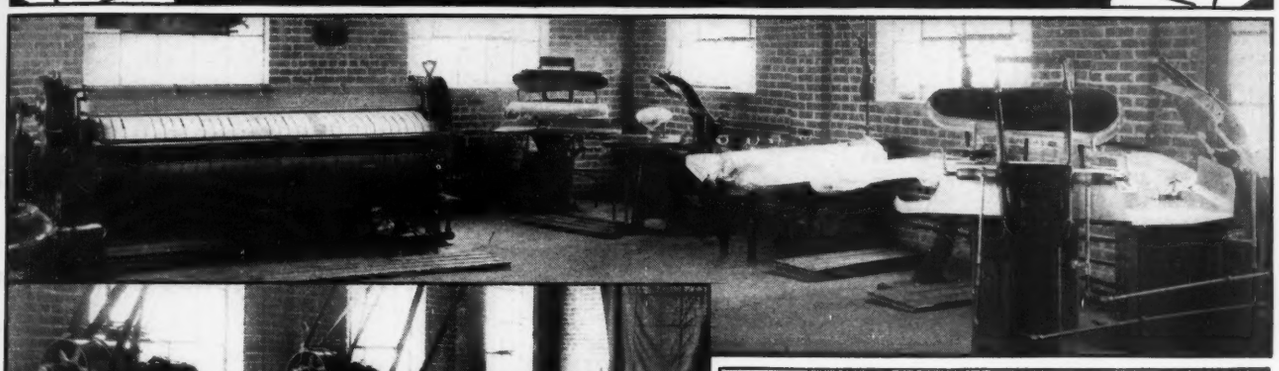


★ WILLIAM GORGAS ★

Revealing the fact that yellow fever was transmitted by the mosquito, and perfecting sanitation measures to combat spread of the disease, William Gorgas (1854-1920) saved thousands of lives, won a deserved place in history alongside those pioneers whose accomplishments are recorded as medical and surgical achievements. In Havana during Spanish-American War days... in Panama while the great canal was being put through... in the South American gold mining districts...William Gorgas fought yellow fever, malaria, influenza... and conquered!

They ADDED THE WORK OF A 165 BED HOSPITAL WITHOUT ADDING to their BUILDING



Above–Finishing department in the laundry at Sacred Heart Convent, Belmont, N. C., with American Return Apron Flat Work Ironer and American Presses.

• • • • • • • •

Left–Monel Metal Champion Cascade Washers, American Underdriven Extractors and Junior Drying Tumbler in Sacred Heart Convent's modern laundry.

Sacred Heart Convent, Belmont, N. C., had a very busy laundry. Besides doing all the work for 30 Sisters and 112 girls at Sacred Heart Academy, it was also supplying clean linens for the 15 Priests and 55 boys at Belmont Abbey.

Then, the laundry work from Mercy Hospital, at Charlotte, was added. This meant clean linens for 165 more beds and for the hospital's personnel of 65 nurses and 15 Sisters. An addition to the building, at Belmont, seemed imminent.

Before work on the addition was begun, however, an American Laundry Advisor was called in. First, he made a complete survey of the requirements for handling the additional capacity. Then he submitted his recommendations. Instead of larger quarters for the laundry, his proposal specified modern, more productive equipment capable of easily handling all the added work, in exactly the same floor space. So, Sacred Heart Convent saved the cost of an addition to their building.

When you are confronted with a problem concerning your laundry department or your laundering methods, call in an American Laundry Advisor. His practical experience and thorough knowledge of laundry department operation and planning are always available to you without obligation.

Ask FOR
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LAUNDRY ADVISOR
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The AMERICAN
LAUNDRY
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SAL
Vol. 49,

The Editor Talks It Over

West Virginia Experiment

• In the *Survey Graphic* for November, 1937, is an account of the discovery by a physician and a compensation official that physical rehabilitation is much less expensive than relief. Omitting any consideration of the humanitarian angle of the problem, it was found that the cost of hospital and medical fees would average about $120 per person while the cost of maintaining such unemployables is $230 per year. At first, ten selected cases were given medical care, the expense of which was met by the state. Nine promptly got jobs. This ratio persisted in the experience with larger groups. West Virginia is now spending $50,000 a month for the restoration of potential bread-earners on relief. The moral of this story is clear. Sick men cannot earn their living. The hospital and its staff can open the door that leads back to self and family support at one-half the cost of continued relief.

Incidental Blessings

• "Today the people were not kept at work. They were allowed full rations of meat with an extra allowance of suet for dumplin's or a kind of boiled puddin'. All men were allowed a quart of four-penny beer—the women a pint —and all were given tea and sugar."

This is a description of the festivities of Christmas Day, 1789, as recorded in the minute book of the superintendent of the Philadelphia Almshouse, the infirmary which was the progenitor of all hospitals in the United States. Not a day of feasting, to be sure, but even in 1789 this institution did not allow the day to pass unnoticed.

From such small beginnings sprang the cheerful and often extensive hospital celebration of today. Christmas is the children's day. Staid doctors and nurses for the time become the fathers and the mothers of the tots who are unfortunate or lucky enough to be patients in the hospital on this holiday. Little sleep will the staff get "on the night before Christmas." Once the ward is darkened, out of the queerest of hiding places come fragrant trees, gaudy tinsels, candies and gingerbread men. And, lo! as the great day arrives childish sleepy eyes see instead of the familiar ward surroundings a veritable fairy land. Not the least of the blessings that Christmas brings is the beneficent effect that its observation has on the members of the hospital's personnel.

Indian Hemp

• On October 1, 1937, the federal government fixed a tax of $1 a year on hospitals and physicians who possess and prescribe *Cannabis sativa* in any form. Indian hemp, or hashish, is produced in the Far East. American hemp, or *Cannabis americana*, of high active potency grows in the vacant lots and out of the way places in many an American city. This drug is of little use in medicine and it has villianous qualities. It is occasionally used as a sedative by the doctor and, even though this is rare, the hospital will probably wish to keep it in some form on its shelves so as to meet this unusual call. While the government requires $1 a year tax from hospitals that dispense cannabis it will have to make growing the weed unpopular if it hopes to succeed in its campaign of suppression. Incidentally, marijuana, cannabis and hashish are terms used interchangeably.

Ironing Out Differences

• In an editorial in *Southern Medicine and Surgery*, the writer states as his belief that a purge of the hospital staff once in a while would be a wholesome procedure and would make for better cooperation. The title of this editorial was terse and highly suggestive. "Let's Call a Spade a Spade." It stated, in effect, that difficulties never arise between the staff and the hospital management without there being a modicum of right on each side. Staffs do not always play fair with hospitals. They assume a proprietary attitude which is generated by the fact that physicians send patients who usually pay their bills to hospitals and hence make possible the meeting of the hospital's accounts payable. Institutions do not always accord the opinions of the staff the proper attention and respect. On the other hand, they permit staff members to believe that once appointed, always appointed. Annual reappointments, each name being carefully scrutinized as to the service rendered to the institution in the past year and as to loyalty, helpfulness and cooperation given, serve to dispel the belief in the minds of physicians that a perennial place on a hospital staff is their due.

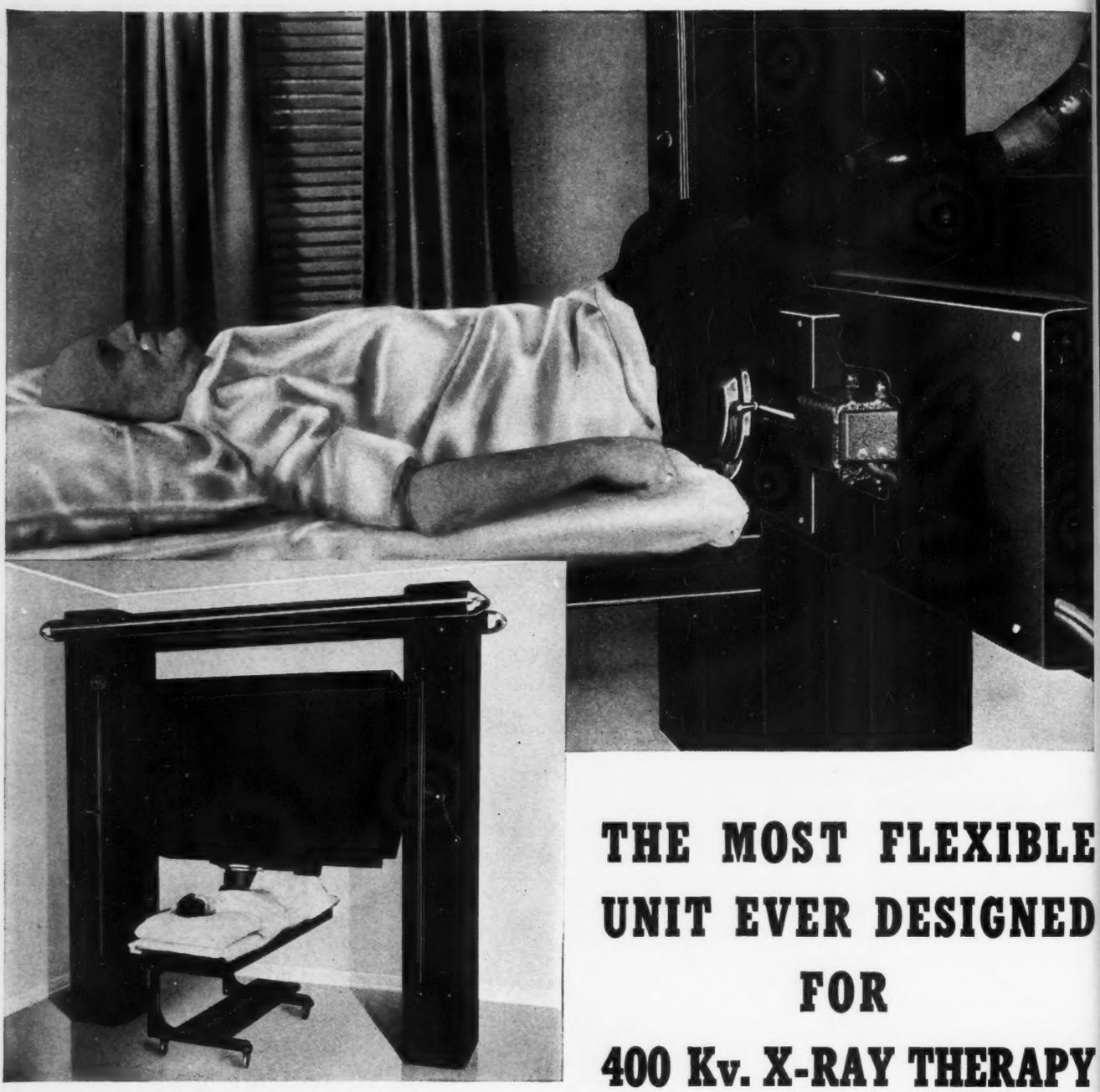
Fish or Fowl

• Some may conclude that goldfish and canaries are inappropriate residents of a children's ward. Yet have you ever observed the joy such pets bring to convalescing children and even adults? 'Tis hard to harbor the blues when canaries trill with joy when bathed by a ray of sunshine and goldfish lazily bump their noses against the walls of their glassy homes in search of food.

No Smoking, Please

• That Lady Nicotine is not wholly friendly to the new-born seems to be indicated by the results of a questionnaire reported by Doctor Campbell in a recent issue of the *American Journal of Obstetrics and Gynecology*. Smoking mothers do not always give birth to healthy children. It is the belief of seventy-five eminent obstetricians throughout the country that acute or chronic nicotine poisoning through the abuse of cigarettes is capable of harming the unborn child.

Without assuming a puritanical or self-righteous attitude, therefore, it would be sound to teach in the prenatal clinic of every hospital that moderation in the use of cigarettes, if not complete abstinence, is advisable during prenatal periods.



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IN the new G E Maximar "400" you'll find not only unusual compactness which conserves valuable floor space and assures an economical installation, but also exclusive features which make it the most flexible unit ever designed for x-ray therapy up to 400,000 volts.

Incorporating a *motor-operated* mechanism for vertical adjustment of the tube head, and a means of angulation, convenient positioning to all parts of the body is quickly and easily obtained, with utmost comfort for the patient.

Self-contained, the Maximar "400" represents a single-room installation—a room approximately 14 feet square will accommodate it. Oil-immersion of the entire high-voltage circuit within the tube head makes its operation shockproof, and free from the effects of variations in humidity and altitude.

Wherever the need for 400 kv. therapy service is indicated, the G-E Maximar "400" makes it possible to equip practically, economically and efficiently.

The completely illustrated catalog will interest you. Ask for Lit. No. F112.

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Looking Forward

A Gift Horse's Mouth

AN UNUSUAL gift to Blodgett Memorial Hospital, Grand Rapids, Mich., has just been announced. John Wood Blodgett, founder of the hospital, has given the institution two sums, one to clear up all present indebtedness and the other intended to prevent any future indebtedness.

The first sum of $125,000 is to be devoted to paying all of the hospital's outstanding debts. Acceptance of this part of the gift is conditional upon accepting the second sum also. The latter portion is $100,000 par value of securities to be held by a trust company as a permanent and irrevocable trust, the income of which will go to the hospital each year provided the hospital always has on hand at least one and one-fourth times as much cash and accounts receivable as it has debts and obligations. If during any ninety-day period for any reason the hospital shall not maintain this ratio, it will lose not only the interest but also the principal. The sum then becomes permanently payable to another organization.

In order that the terms of the gift shall not act as a bar to progress, Mr. Blodgett further stipulates that certain sums must be expended to maintain and modernize various aspects of the building and its equipment.

Such a gift puts heavy pressure upon the trustees of the hospital to keep it always in a sound financial condition. This is undoubtedly desirable. But the experience of those who have devoted much study to charitable trusts indicates that it is rarely wise to tie up any gift in perpetuity with iron chains. Conditions change and with them the needs of the public. The late Julius Rosenwald wisely provided that both the principal and interest of his bequests should be expended within twenty-five years of the date of his death. Thus he indicated humility in respect to his own ability to predict the future and confidence in the ability of succeeding generations to determine what charities they wished to perpetuate and to find the money to do so.

Mr. Blodgett's fine gift is not sufficiently large to prevent a courageous board of trustees from surrendering it, if in the light of radically changed conditions such course seems wise. Nor apparently is it restricted to any one small segment of hospital work, a segment that might in the course of years become unnecessary. Hence it is preferable to many gifts in perpetuity.

In general, however, hospital trustees would do well to accept only such gifts as do or can be fitted into a rational service program for the institution and offer enough flexibility to permit the hospital to change its function in accordance with changed demands. Any social institution will be sounder if, from time to time, it must go before the public and justify its existence.

Factors Influencing Hospital Cost

ECONOMIC trends are reflected slowly in the hospital rate card. The hospital habitually and patiently absorbs rising costs without complaint before deciding that an elevation of hospital rates is necessary. The charges of a physician are just as certainly affected by economic changes. Rents, the general cost of living, the ability with which fees are collected and the gradual rise in overhead costs produce the necessity on the part of the doctor of increasing his income. In the case of the hospital, any readjustment upward of commodity costs either results in an unusual increase in deficits or else forces the board of trustees to alter room and special service charges.

In many states the hospital today is facing the enforcement of laws limiting the number of hours that an employee may work. In several states the forty-four-hour week is required for male as well as female employees. Furthermore, no hospital employee may work longer than eight hours a day and this period may not be

spread over a greater time than twelve hours.

How the hospital is to adjust its financial structure to such drastic legal requirements is difficult to understand. At the same time that hours are being shortened, the members of the hospital personnel are demanding a higher recompense. To make the institution's dilemma still more embarrassing there is the ever-increasing public demand for refinements of medical service that are costly both in physical equipment and in personnel.

As in the case of the individual, the cost of living on the part of the hospital has far outstripped its income. Some believe that hospitals should not be exempted from legal requirements, even though they increase operating costs. Others insist that, because of its charitable nature, the institution should be allowed to carry on as heretofore regardless of trends in industry. If the former opinion prevails, then the hospital must gradually approach hotel room rates as a first cost and add thereto the expense of supplying all of those services which are not required of institutions that provide bed and board only. Government restrictions on the work of the hospital are becoming ever more exacting and expensive. In the end the public which elects lawmakers who enact such restrictions and demands must pay for carrying them out. This is a lesson that the public at large has yet to learn.

Hospital and Research

THE chief business of the voluntary hospital is the prevention and cure of disease. The task of large foundations and research laboratories is to carry on the expensive process of delving into the secrets of chemistry, bacteriology and pathology insofar as they affect the cause of such great unknowns as cancer and cardiac and degenerative diseases. It is splendid when a preventive and curative institution can combine with these activities the prosecution of research. But the money contributed by a community for the care of the sick should not be diverted into the expensive channels of research. If endowments specifically directed toward this end can be obtained, the voluntary hospital may well carry on investigative activities. The average general hospital, however, cannot hope to compete either from a scientific or a physical angle with the great foundations.

Money contributed to the general hospital for research and spent by those neither scientifically nor temperamentally fitted for research is money thrown away. Bad research is worse than none at all. If the general hospital is to conduct investigations into problems affecting the cause and cure of disease, let it be along lines that are consonant with the amount of money available.

None of this is said to deprecate the value of research. All will agree that the scientific stimulus which comes to an institution from the conduct of good research is of the highest importance. Nevertheless the voluntary hospital should stick to its last—the relief and the prevention of suffering.

Credentials Committee

EVERY hospital staff should have a credentials committee which should consist of physicians who possess courage, vision and tact. This committee, perhaps of all groups in the staff organization, can be most life-saving in its activities. On the other hand it can endanger life through a craven desire to forward its own personal interests and permit unqualified physicians the privilege of the hospital operating room.

The classification of the hospital staff as to the surgical privileges which its members may enjoy is an important function of this committee.

Resolutely to forbid a rash or untrained physician to perform major surgery is its plain duty. Just as courageously to defend an unpopular yet highly skilled surgeon when he is prevented from operating because of jealousy is also an obligation of this group.

This committee must have good judgment. To evaluate experience or lack of it in terms of surgical ability is not easy. To refuse a request from an untrained surgeon who is socially, financially or politically prominent requires a fine type of devotion to the patients' interests. The credentials committee of the staff can make or break the hospital's reputation.

Contentious Times

THE hospital has been living in a fool's paradise. It has thought that its position isolated it from the practices of business. It believed that some things were sacrosanct, that the protection of public health, the cure of disease, the supervision of births and the softening of deaths placed it in a position of community respect which guaranteed, as does the flag of the Red Cross, immunity from attack in battle.

This belief apparently has had no basis in fact. In warfare the bombing of an institution for the treatment of the wounded may be accidental. An attack on the voluntary hospital can represent nothing but a deliberate assault. Having passed through a period of the greatest of

economic difficulty, the hospital now is faced with an attack from within that is even more difficult to combat. For the power of almost one million employees who care for the 800,000 sick in the field has at last been discovered.

We read of labor troubles in the utility field as a by-product of which light, heat and power are denied the local hospital. In one instance an operating room was left in darkness because laborers in a near-by utility refused to work. This behavior, if it occurred in some states, would and should be indictable since the very lives of hospital patients are endangered thereby.

Such difficulties in the hospital are not entirely without explanation, when the type of the hospital's personnel and their wages and hours are considered. Many are faithful and generous to a fault, many are improvident, simple-minded and easily led. They offer little resistance to the arguments and cajolings of the shrewd organizer. They forget the hospital's kindnesses of the past when told the millenium has come.

But, in spite of the great army of hospital workers, only here and there have groups actually endangered by mass action the welfare of the sick. One cannot but believe that even the most cruel and ignorant will again lift their eyes from the ground of their own self-seeking and observe that on the institution which they are attacking still floats the traditional banner of self-forgetfulness and of self-sacrifice. Especially will this be true if the hospitals will clearly demonstrate that they do have the interests of the lower paid workers at heart.

Group Plan and Ward Patient

ALL sorts of claims and counter-claims have been made for and against group hospitalization. There are those who purport to believe that this plan will wreck the hospital financially and that it is a sure approach to socialized medicine. Others believe as certainly that this plan is the surest way of preventing interference by the state or federal government in the treatment of the sick.

But upon one point there is less divergence of opinion. Many patients who are able to pay the full ward rate, upon finding that they may occupy semiprivate facilities by enrolling in a group plan will certainly in the future be found in the latter type of accommodation. Moreover, there will surely come a like stepping up of former semiprivate patients into private rooms. This probable change in institutional status of the hitherto semiprivate has been estimated at anywhere from 10 to 20 per cent. In those institutions having long waiting lists for ward beds indirectly group hospitalization will assist those who cannot pay for institutional care. Every ward bed that is vacated because its former occupant enters the semiprivate ward will be made available for those who cannot pay for even public ward care.

What Is Loyalty?

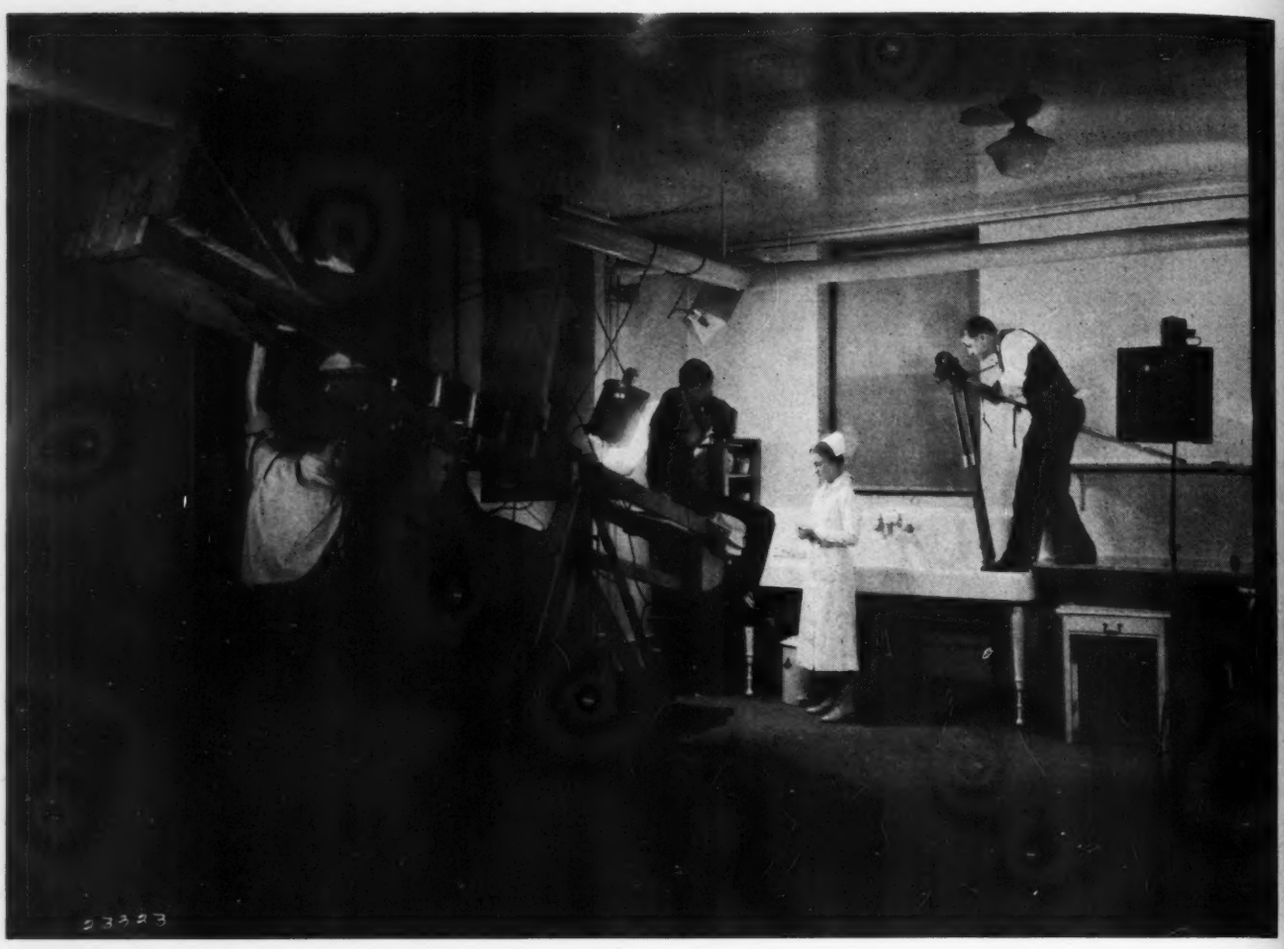
THAT abstract quality which has been given the name of loyalty is difficult to define. To some it may mean a blind adherence to the wishes of one's superiors. To others a lip service only, and to still others the exemplification of belief in the eternal values of principles rather than the transient devotion to personalities. There is a type of hospital worker who, desiring to obtain some end, begins far away from the institution to interest someone in bringing pressure on a second, third or fourth party and finally upon the superintendent or the board of trustees. In colloquial language, these make the balls for someone else to throw. Even though trails are carefully covered, this type of person sooner or later is revealed in his true light.

There is something manly about that hospital employee who goes to the superintendent with his requests and accepts a victory or a defeat with the belief that, after all, such action is probably best for the hospital and its patients. There is much that is cowardly in that person who, being reputed as loyal, lays deep schemes to influence board members to require his immediate superior to comply with his requests. Loyalty to an institution is not loyalty to its executive but to its patients. To undermine an executive destroys morale and harms the sick.

Congratulations and a Warning

AGAIN the need for trained hospital administrators is recognized! As announced in our news columns this month, the Commonwealth Fund has made a grant to the University of Chicago to continue the course which has been offered there for the last three years. This is to be carried on in conjunction with the American College of Hospital Administrators.

This is an excellent move. The Chicago course is of high standard and there has been brisk demand for its graduates. Other universities are interested. Before they proceed, however, it would be wise if they consulted the A. C. H. A. Too many training courses, or courses of low grade, would be as bad for the administrative field as it has been for the field of nursing.



Nurse Training

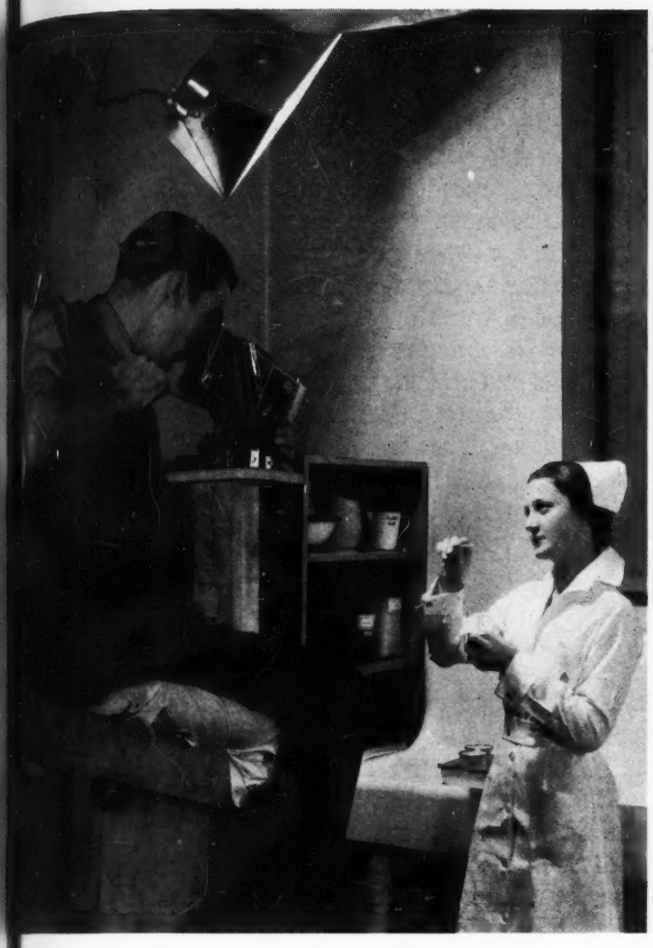
By LOUISE WAAGEN, R.N.

MOVING pictures have entered into the field of education during the last few years. By this medium teachers have been able to bring to students materials otherwise beyond reach of the average classroom. Seeing and doing are two of the greatest mediums of learning. These are the bases upon which nursing educators plan their teaching.

Since so much time and effort have been spent in the preparation for "demonstration classes," members of the University of Minnesota faculty became interested in the possibility of filming some elementary techniques of nursing. This was first proposed as an experimental project and soon tentative plans were drawn. After considerable discussion, the following were chosen as representative techniques, and the finished work includes reels of: the open bed; morning care; evening care; temperatures, pulse, and respiration; the hot foot bath; the bed bath; treatment for pediculosis and a shampoo in bed, and the removable backrest.

The pictures were made to be used as educational pictures and to replace demonstrations of the nurse instructor. Directly responsible for the plans were Malcolm McLean, dean of the general college; Katharine J. Densford, director of the school of nursing; Barbara T. Thompson, then superintendent of nurses at the Minneapolis General Hospital; Robert A. Kissack, Jr., cameraman, director of visual education at the University, and Louise Waagen, demonstrator, then assistant instructor in the school of nursing. A graduate nurse was kind enough to be our patient.

Considerable time was consumed in completely outlining plans before actual shooting began. Since the films were to be used as a teaching device, each step in each procedure had to be filmed. Also, the whole series of films had to be definitely unified and integrated with the rest of



Goes Visual

At University of Minnesota

the teaching schedule. Whenever units of one technique were repeated in more than one procedure, this technique was filmed in complete and detailed form in the first pictures of the series. To save time and film, as well as unnecessary classroom time, this unit, when appearing again, was made as a dissolve, *i.e.* the fading of the beginning of the unit into its completing steps.

The project was begun with some of the elementary techniques the student nurse meets early in her experiences. These were analyzed carefully as to efficiency, efficacy, time required for correct performance and integral parts. Each procedure was broken into its constituent units for ease and effectiveness of filming. Numerous close-up, slow-motion and travel shots were planned and used in order that all important action, simple or complex, could be portrayed clearly. The script, then, was the result of careful analysis and planning for the final step of work — the actual shooting.

Of prime importance are periods of practice for the demonstrator. A demonstration technique must be perfected so that it never varies from one performance to another. Each time it must synchronize with the camera time.

Proper equipment for this work, camera, lens, lighting and adequate materials for the demonstrations, must be carefully selected. Our pictures were shot at sound speed on 16-mm. film so that lectures may be synchronized with them later on sound films.

Only an approximate figure can be stated as to the time required to take the pictures. It took from 18 to 20 hours to film each demonstration. Time spent in practice and planning is not included in these figures. The films were sent to Chicago and Hollywood for developing, but the cutting and previewing were done at the University of Minnesota in the shops of the visual education department. Out of the 6,000 feet of negative taken, about 4,000 feet were used in the finished pictures. The approximate cost of materials, exclusive of salaries, was $1,200.

The films were first used as a teaching device in June, 1934, and results were so satisfactory that the films have been used for each class since that time. When used in the classroom, a lecture and class discussion of the daily assignment precede projection of the picture. This discussion includes purpose, underlying scientific principles, indications, contra-indications and a general description of the technique to be studied. Following this, the picture is shown, accompanied by an explanatory lecture. During the projection the lecturer specifies important steps and stresses various angles of the topic. Following the first showing the students are given an opportunity to ask questions. Then the picture is shown a second time, during which period the instructor does not give the complete lecture, but only stresses to the students parts of the procedure of which they were in doubt. Each film is shown twice. Then students are given the opportunity of individual practice in the classroom. Two or three days later the picture is presented a third time for review, and to fix the subject in the students' minds.

The uses of the pictures may be said to be twofold: first, as a teaching aid, and second, as a medium for educational study. In discussing the use of these films as a teaching medium, one

might best treat the subject as to advantages and disadvantages. The advantages of teaching with the moving picture method over the teacher-demonstration method appear to be these:

1. The films represent a uniformity of technique regardless of the number of times repeated. There is no chance of error or loss in continuity in personal demonstrations. Students in the school of nursing are rotated among four hospitals to complete required experiences. By use of these films, instructors in the respective institutions can feel assured of a uniformity as to the method in which the techniques are taught.

2. The films are definitely time-saving for the instructor. By the old method, the teacher spent a disproportionate amount of time in the collection of equipment and in teaching time. Not only was time spent before the class began, but afterward, as well, when all of the materials had to be put away. Time can, obviously, be much more effectively spent supervising the bedside work of the student nurse.

3. The value of repetition in effective teaching and learning cannot be denied. This is an important point; with the films the same technique can be shown twice in the time required for one personal demonstration.

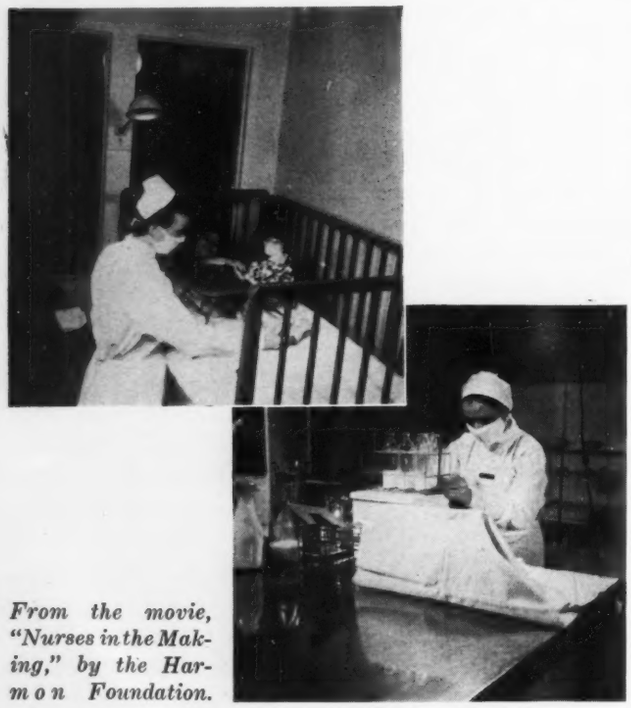
These Are Disadvantages

The advantages far outweigh the disadvantages. Nevertheless, there are three disadvantageous points to be borne in mind:

1. With the movie method, chiefly techniques can be shown. The teachers, however, by example and lecture, may stimulate the student to realize the meaning of "fine nursing" and "personal interest" in the patients.

2. It is obviously difficult to portray the adaptability of the various techniques, such as the care of the patients with casts, traction, special surgical dressings, and in oxygen tents. These films are meant to teach the elements of nursing and modifications may be acquired by the nurse in clinical experience. Most schools of nursing use this method of teaching even when teacher-demonstration is the classroom practice.

3. In the event that at some future time the technique needs to be changed, portions of the film may be redone. The expense involved is, of course, the detaining factor here. This difficulty has been avoided to some extent by careful analysis before our pictures were filmed.



From the movie, "Nurses in the Making," by the Harmon Foundation.

How Helpful Are Movies?

Since the pictures have been used, a study has been made to draw statistical conclusions concerning the educational value of this method of teaching. This study was conducted by Ida MacDonald, instructor at the Minneapolis General Hospital, under direction of Dr. Harl R. Douglass of the university college of education. Each class was divided into two similar groups, each group having students of like ability as rated by the college ability tests at the University of Minnesota, high school grades, I. Q. ratings and class grades during the first quarter's work at the university. One group was taught by the teacher-demonstration method, the other, the movie-demonstration method. Although the statistics are not yet completed, from experiences resulting from the pictures thus far, some tentative conclusions have been drawn:

1. Students taught by the movie method seem to have a clearer outline in mind of procedure methods. They spend less time organizing and beginning laboratory and clinical assignments.

2. They apparently make fewer errors, even in finer detailed work. We feel that the students have, with this new teaching method, a definite division between lecture and demonstration—that they see a clear-cut beginning, as it were, to the manual nursing assignment. This probably explains the readiness with which they do "return demonstrations." The change in presentation of material, from lecture to picture projection, in the same class hour holds interest and stimulates attention.

No further plans have yet been made to film additional nursing demonstrations. The present results have been so pleasing that additional "procedures" may be recorded on a 32-mm. film with a synchronized lecture in the near future.

Vista along the rain-drenched driveway of Duke Hospital.

Flat Rates for 4½ Years

By F. V. ALTVATER

IN APRIL, 1933, Duke Hospital, Durham, N. C., adopted the flat rate, cash-in-advance system, by which the patient, whether he pays private rates or less than cost, pays a definite sum per day based upon his ability to pay and agreed upon in advance. The plan was started because:

1. It was felt that "wise charity is an enlightened principle, but complete charity prostitutes the character of a people." The psychology of full charity was wrong.

2. Most patients from whom we previously had been unable to collect told their friends and relatives of the fact, and as a result the admitting and credit officers were becoming more and more helpless with each successive turnover of patients.

3. It was thought that the more exact an estimate of total expense could be given before admission, the easier it would be to enforce payment in advance for the full estimated length of stay.

4. Hospital rate structures seemed to bear little relationship to costs. A common occurrence was to charge the patient for his room roughly to correspond with the per diem cost plus a score of extras — but the cost of these extras to the hospital was already a part of the per diem cost used for figuring the room rate alone. Even were this not true, the usual practice of hospitals was to model their rate structures after those of hotels. A guest in a hotel, however, uses his own free choice in ordering extras, most of which are luxuries, but a patient in a hospital does not have this choice or if he does have it necessary procedures will often be omitted to his detriment.

A hospital is the one place in which a physician can work most effectively, and because of this, hospital attention has become more and more a necessary part of our standards of living. People

now seek hospitals for many illnesses for which their fathers and mothers of a generation ago would not have dreamed of leaving their beds at home. If this concentration of diagnostic and treatment facilities is the real reason for the increasing acceptance and usefulness of the modern hospital, then it seems unintelligent to make these facilities, these extras, more difficult to get.

Excerpts From Patients' Information Folder

Charity — All charity (part of cost paid by his county, city, church or welfare association) and semicharity (part of cost paid by patient or his family) patients must be examined in the Public Dispensary before the question of admission to the hospital will be decided. Often all beds are filled. Have your family physician or welfare officer write, wire or telephone the assistant superintendent in charge of admissions, Duke Hospital, Durham, N. C., for appointment or reservation.

Private — Private and semiprivate patients should make their reservations in advance by communicating with the assistant superintendent in charge of admissions or the member of the staff to whom the patient is referred.

Rates of the Hospital — The following rates include the usual extra charges (operating room, x-rays, drugs, dressings, laboratory fees, special tests and procedures, etc.). *No one may be admitted without paying cash in advance or presenting a guarantee from a responsible financial, business or welfare organization. Any unused portion will be refunded.*

CHARITY — $21 first week, $14 per week thereafter. Refund of $2 per day for every day less than a full week (must be paid by city, county, religious or welfare organization).

SEMICHARITY — $28 to $49 first week, $21 to $42 per week thereafter. Refund of $3 to $6 for every day less than a full week.

SEMIPRIVATE — $31.50 to $52 first week, $24.50 to $42 per week thereafter. Refund of $3.50 to $6 for every day less than a full week. *Doctors' fees in addition.*

PRIVATE — $52 to $115 first week, $42 to $105 per week thereafter. Refund of $6 to $15 for every day less than a full week. *Doctors' fees in addition.*

5. Since an analysis of patients' bills in our hospital proved that there was little spread between the average bill of the medical service patient or the surgical patient or the orthopedic patient and the average bill of all of them, it seemed logical to charge the same per diem flat fee for all. And since the American people were thoroughly familiar with the principle of spreading risks and costs through insurance, it was believed logical that they would readily accept the payment of some additional fee per day to be freed from all financial worries as to how many x-rays, drugs, dressings, anesthetics, oxygen therapies and physiotherapy treatments would be required for them.

These five points constituted the case for all-inclusive flat rates (no extra charges) and for cash-in-advance and no full charity admissions. During the four years and a half that this plan has been in effect, these results have been noted:

1. Of patients (not in an emergency condition, since these are not refused) who were sent away because of no funds or no social agency to pay for them, more than 90 per cent returned with proper financial arrangements.

2. Thirteen counties paid something toward their patients' bills in 1932. Seventy-five counties assisted in 1936.

3. Average per patient per diem collections, while still below per patient per diem costs, increased by 129 per cent. There was at the same time an increase of 67 per cent in the number of patient days. The average stay in the hospital in 1932 was thirteen days; now it is four days.

4. In 1932 there were several arguments each day at the cashier's window about the amount of the bill. In 1937 about the same number of arguments occur during the course of a month! The number of well satisfied patients has increased.

5. Although it may be thought that the inclusion of extras into the flat rate structure would markedly increase the number of these extras and thus skyrocket the cost of running the hospital, to the contrary the following has resulted: the expenditures of the x-ray, pharmacy and physiotherapy divisions, for example, increased 74 per cent from 1932 to 1936 as against an increased hospital patient load of 67 per cent, while the per patient per diem costs decreased from $5.43 in 1932 to $4.51 in 1936, a year of high costs.

6. There has been a collection record of 96 per cent of all private patients' charges and 91 per cent of all less-than-cost charges* in 1936. In 1932 nearly 80 per cent of the patient days were wholly free. In 1936 less than 10 per cent of the patients did not pay at least $2 per day.

7. The results of this plan, plus the general recovery in business, has meant that Duke Hospital has been able to care for nearly twice as many less-than-cost patients with the same endowment.

The present rate structure can best be understood from the accompanying information pamphlet issued by Duke Hospital. The necessity of the additional charge for the first week of stay, begun a year ago, was occasioned by the sharp reduction in the average length of stay.

*Durham city and county figures are excluded. Durham patients comprise 12½ per cent of the total. Durham city and county charity donations cover only 40 per cent of the charity rate of $2 per day, or 18 per cent of the cost.


Hospitals Have Wide Chimneys
and Santa slips down with a full pack

That Makes It Unanimous

IN 1933, the American Hospital Association, acting through its council on community relations and administrative practice, approved the principle of "group hospitalization" and adopted a set of guiding principles. These principles, although they have been somewhat modified and expanded during the intervening years, still serve as the guideposts of the committee on hospital service. In 1937 the bureau of medical economics of the American Medical Association published a study of group hospitalization running as a

1933 Statement of A. H. A.

1. Emphasis on Public Welfare: Group hospitalization should be organized, in principle and in fact, as a public service. Subscribers should be invited to participate in the administration of group hospitalization plans.

2. Limitation to Hospital Charges: The plans which the council of the American Hospital Association has approved cover payments for hospital care only and do not include payments for the professional services of physicians and surgeons rendered to patients. The usual relations between physician and patient are not altered.

3. Enlistment of Professional and Public Interests: In establishing plans in any locality advice should be sought and interest should be enlisted from the medical profession, hospital trustees and other qualified persons or groups interested in public service, such as social workers, nurses, lawyers, insurance men and industrialists.

4. Choice of Physician and Hospital: Subscribers may be hospitalized only when attended by a physician. The subscriber's freedom to choose his physician or hospital remains unchanged. The practice in each institution with regard to open staff and closed staff privileges is not changed. Existing medical staff relations and hospital rules are not affected by group hospitalization.

5. Nonprofit Organization: Group hospitalization plans should be organized and introduced on a nonprofit basis by some existing hospital or welfare association or by one especially formed for the purpose. No individual or group should be allowed to enjoy any "profit" or financial gain from a group hospitalization plan, other than a reasonable and proper return for the necessary services rendered.

After reasonable remuneration has been made to participating hospitals, financial benefits from operation of the plan should accrue to the subscribers. The benefits may be shared either through reduction of subscriptions or increase in hospital benefits.

6. Economic Soundness: Each plan should be economically sound with regard to such details as subscription rates, scope of benefits, remuneration of hospitals, eligibility of subscribers and accumulation of reserves. Compliance with legal requirements is essential. During the experimental stage of any plan, the provisions should be subject to change on reasonable notice, in order that both subscribers and hospitals may be protected from developing conditions that would be detrimental if unchecked.

7. Cooperative and Dignified Promotion: Plans should encourage participation by all hospitals of standing in the community. The ultimate responsibility is assumed by the participating hospitals which agree to render service to subscribers in exchange for the subscriptions collected. The plans should be introduced in a dignified manner, in keeping with the professional ideals of hospital service. Publicity should be limited to the plan itself rather than to participating hospitals. Field representatives may be engaged to introduce a plan either as volunteer or salaried workers, or for specified reasonable remuneration for their services.

The promotion of the group plan should not be placed in the hands of a separate agency which assumes the rôle of contractor for the hospital care. Representatives of the plan should not be allowed to influence the amount of quality of hospital service that is rendered by subscribers.

A. H. A. and A. M. A. Agree on Major Principles of Group Hospitalization

series of thirteen articles in the Journal. The final article, appearing in the issue of Sept. 11, 1937, embodies a series of ten principles. The hospital field will be interested in reading the two sets of principles and noting the many points of similarity. The two associations are apparently coming much closer together in points of view.

Principles Published by A. M. A.

1. The plan of organization should conform to state statutes and case law. The majority of the governing body of the hospital insurance plan should be chosen from among members of official hospital groups and members of medical societies. Great care should be taken to assure the nonprofit character of these new ventures.

2. The plan should include all reputable hospitals. The qualifications of the participating hospitals should be closely supervised. Member hospitals should be limited to those on the Hospital Register of the American Medical Association or to those approved by the state departments of public health or other state agencies in those states in which there is approval, registration or licensing of hospitals.

3. The medical profession should have a voice in the organization and administration of the plan. As hospitals were founded to serve as facilitating means to the practice of medicine, the medical profession must concern itself intimately with plans likely to affect the relations of hospitals to physicians.

4. The subscriber's contract should exclude all medical services — contract provisions should be limited exclusively to hospital facilities. If hospital service is limited to include only hospital room accommodations such as bed, board, operating room, medicines, surgical dressings and general nursing care, the distinction between hospital service and medical service will be clear.

5. The plan should be operated on an insurance accounting basis with due consideration for earned and unearned premiums, administrative costs and reserves for contingencies and unanticipated losses. Supervision by state insurance departments has been advantageous for both the buyer and the seller of insurance contracts. Laws permitting the formation of hospital service corporations should not remove the benefits of such supervision or violate the principles enumerated.

6. There should be an upper income limit for subscribers. If group hospitalization plans are designed to aid persons with limited means to secure hospital services, they should render such service at less than regular rates. If no consideration in rates is made for persons with limited means, group hospitalization plans lose their altruistic purpose and there may be little justification for an income limit.

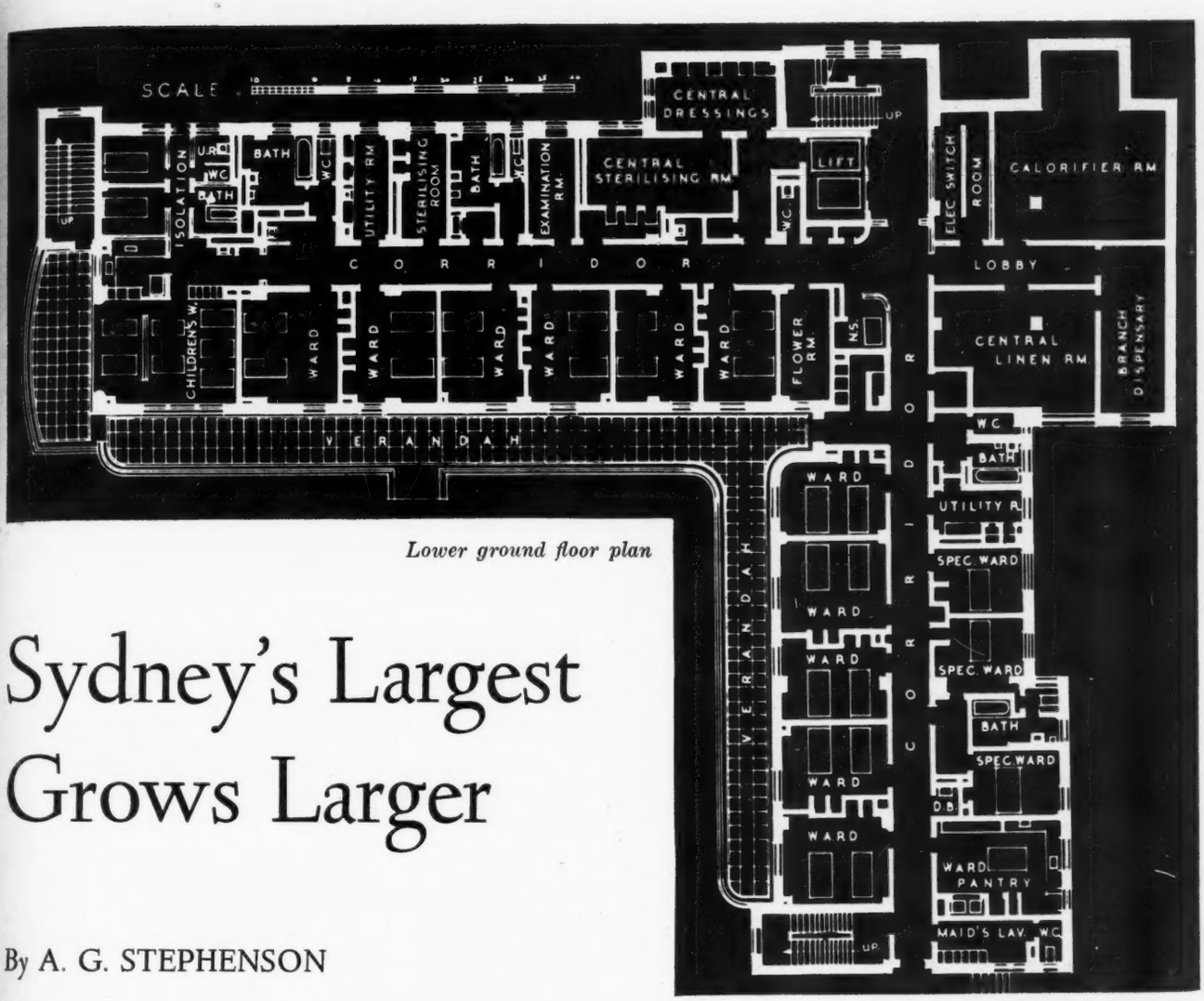
7. There should be no commercial or high pressure salesmanship or exorbitant or misleading advertising to secure subscribers. Such tactics are contrary to medical and hospital ethics and are against sound public policy.

8. There should be no diversion of funds to individuals or corporations seeking to secure subscribers for a profit. The moment hospitals lose their traditional character as institutions of charity and humanitarianism, the entire voluntary hospital system will break down.

9. Group hospitalization plans should not be utilized primarily or chiefly as means to increase bed occupancy or to liquidate hospital indebtedness. Such plans, if they are necessary, should place emphasis on public welfare and not on hospital finances.

10. Group hospitalization plans should not be considered a panacea for the economic ills of hospitals. They can serve only a small portion of those persons needing hospital services. Hospitals must continue to develop efficient methods of administration and service independent of any insurance method of selling their accommodations.

Stair tower of Gloucester House, new unit of Royal Prince Alfred Hospital, Sydney, Australia.



Lower ground floor plan

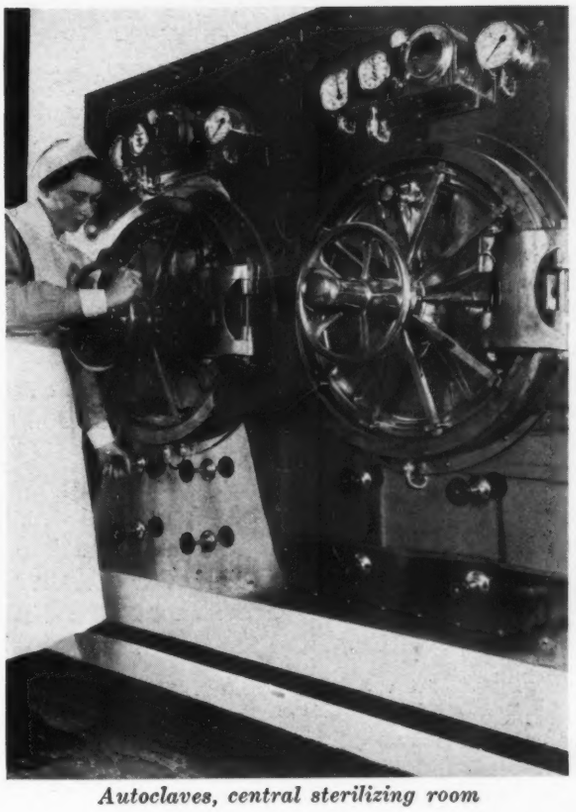
Sydney's Largest Grows Larger

By A. G. STEPHENSON

THE Royal Prince Alfred Hospital is the largest public hospital in Sydney, Australia. It is situated 1½ miles west of the city adjoining the University of Sydney, the physical link being formed by the new medical school endowed by the Rockefeller Foundation. The population of Sydney is approximately 1,500,000. At present 720 beds are provided in this hospital for the acute sick and the hospital is still expanding. Three recent additions are an intermediate block, an x-ray block and a power station.

The hospital opened in 1883 with 146 beds. By 1935 the number had increased to 570 of which 25 were for intermediate or part-paying patients. This department proved so popular that the board decided to build a new block of 150 beds for intermediate and private patients and in August, 1936, this block, named Gloucester House, was opened. The Royal Prince Alfred Hospital has a closed staff and only the 137 members of the honorary staff may send patients there.

The site chosen was close to the southern bound-



Autoclaves, central sterilizing room

ary of the hospital grounds and in convenient relationship to the operating block, to which it is connected by a covered bridge at the third floor level. The connection with the central kitchen is by a similar bridge on the ground floor.

Aspect and simplicity dictated the form of the plan. In Sydney cold winds and rain come from the South, and dry winds, hot in summer, cold in winter, come from the West. The ideal aspect is northeast, the direction of the light, cool summer breezes. The cantilevered balconies facing north and east on the inner side of this L-shaped plan enable the patients to enjoy the sun in winter protected from cold winds and in summer to enjoy the cool breezes. The long lines of the balconies, unbroken by any vertical support are not only restful to the eye, but allow a maximum of sun and air to enter the wards. Owing to the temperate nature of Sydney's climate, it is possible for convalescing patients to use these balconies the greater part of the day practically every day of the year. In addition each floor has a glazed solarium at the eastern end.

The block is some hundred yards from the street and its noises; wards and balconies, therefore, overlook the gardens of the hospital and the university. The roof solarium is accessible to all patients by the elevators and is protected from the west and south winds. From here a fine view over the city toward the harbor is obtained.

With the exception of a few special wards on the west, wards have a northern or eastern aspect. The wards on the west are air conditioned and are further protected with special external metal sunblinds.

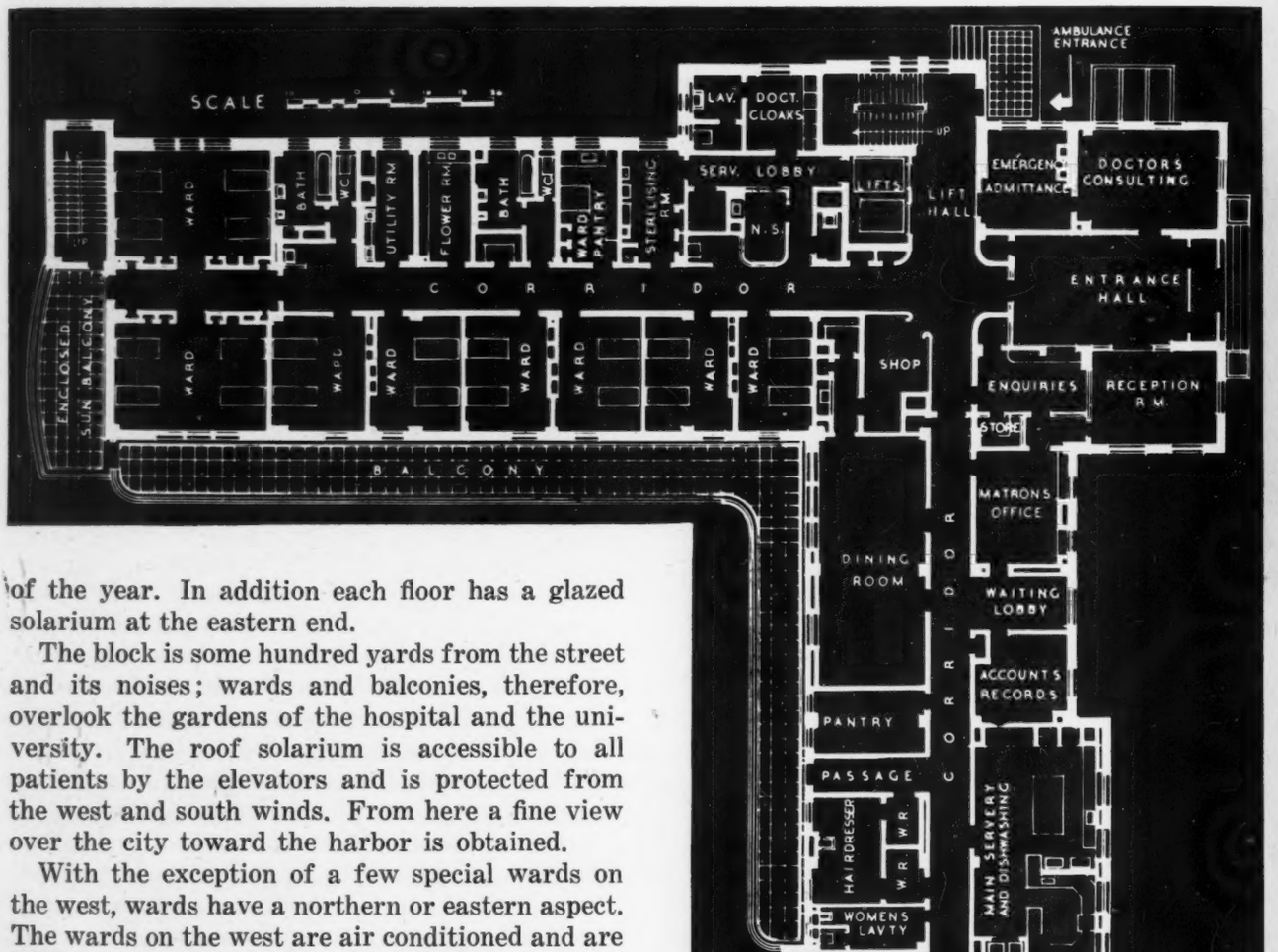
On each ward floor a nurses' station is located at the junction of the two arms of the L. This gives control over both corridors and all exits and entrances. Adjacent also to this station are the visitors' waiting rooms on each floor.

Examination, treatment, sterilizing rooms and stretcher store are located away from the main entrance off a service lobby. Two lifts have been installed, one of which has doors at the back for service and stretcher cases. Flower rooms, linen stores and linen chute are grouped in the internal angle of the L.

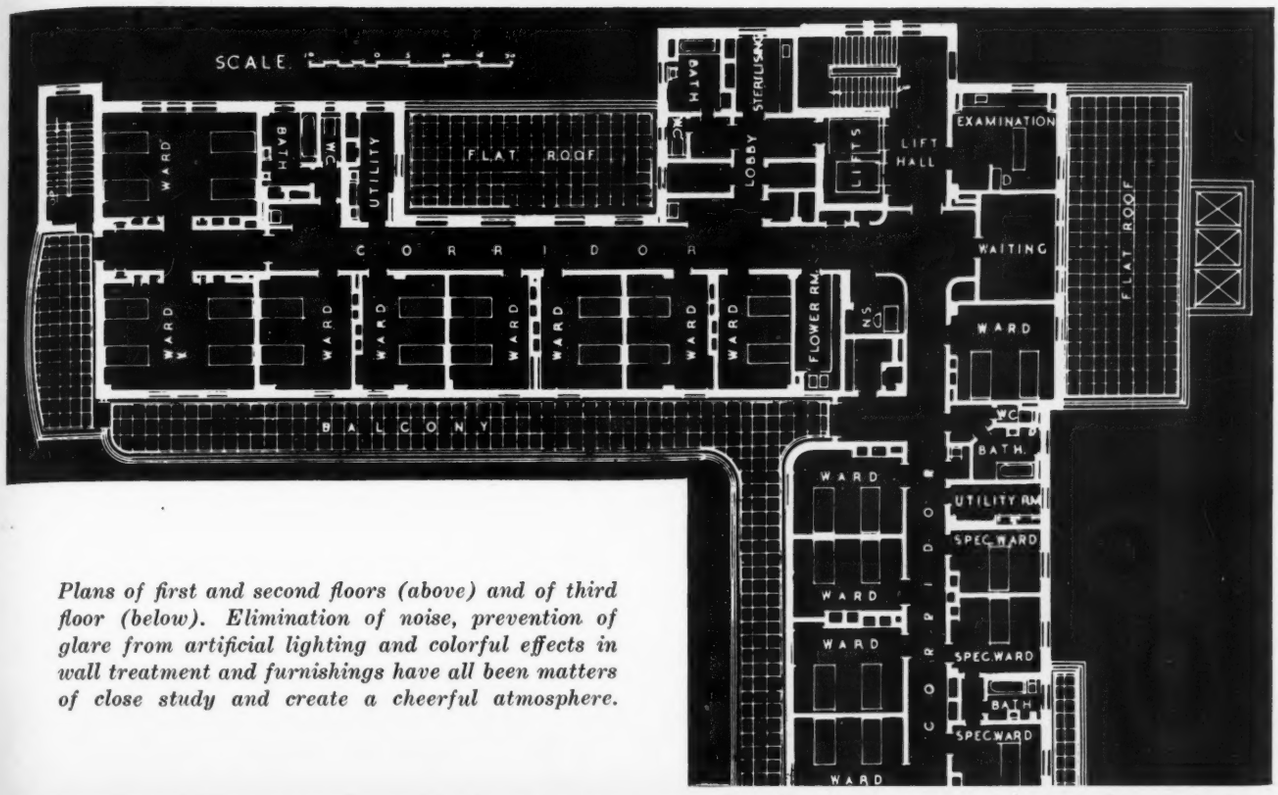
At the bed head of each patient are located a nurses' call and three-channel wireless system, a reading light and a plug-in socket for doctors' examination lights.

The building is five stories in height and each one contains wards on the east and north aspects.

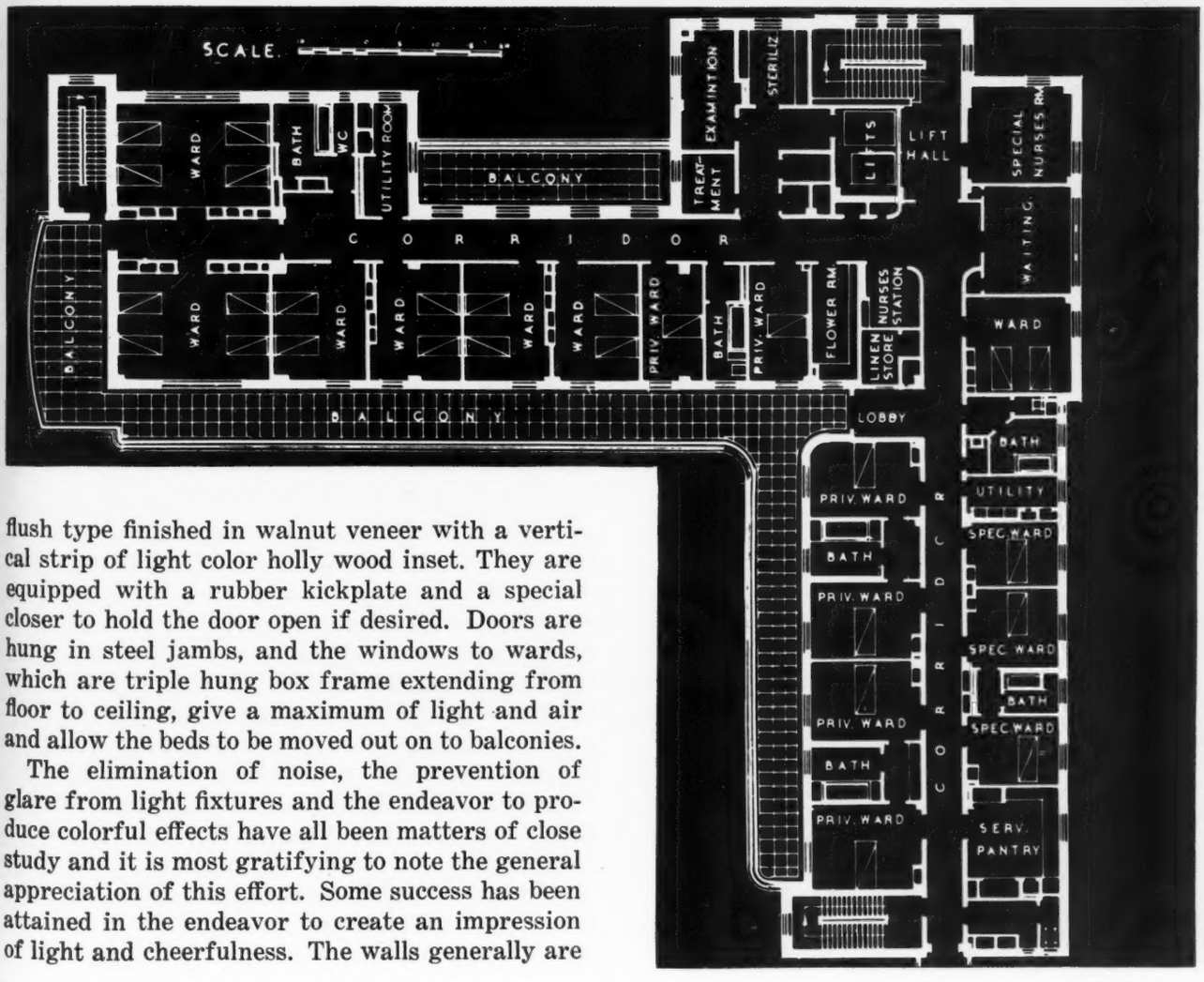
The ground floor contains the entrance hall with inquiry and office, waiting room, matron's office, shop and tea room, barber's shop and central serving pantry to which all food is sent in electrically heated conveyors from the main hospital kitchen. Of special interest are the doors,



Plan of the ground floor of the new Gloucester House designed by Stephenson, Meldrum and Turner.

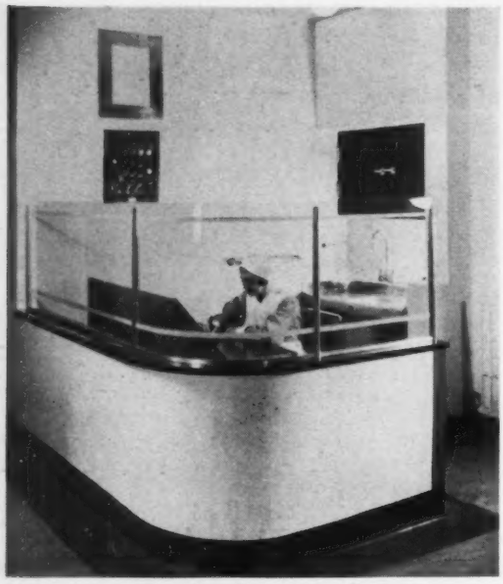


Plans of first and second floors (above) and of third floor (below). Elimination of noise, prevention of glare from artificial lighting and colorful effects in wall treatment and furnishings have all been matters of close study and create a cheerful atmosphere.



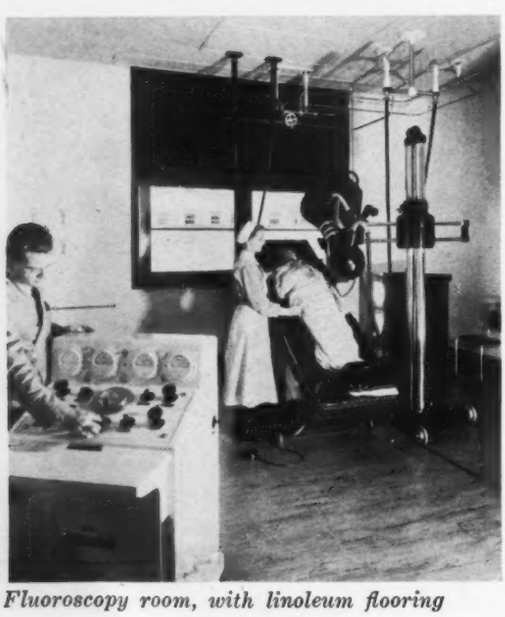
flush type finished in walnut veneer with a vertical strip of light color holly wood inset. They are equipped with a rubber kickplate and a special closer to hold the door open if desired. Doors are hung in steel jambs, and the windows to wards, which are triple hung box frame extending from floor to ceiling, give a maximum of light and air and allow the beds to be moved out on to balconies.

The elimination of noise, the prevention of glare from light fixtures and the endeavor to produce colorful effects have all been matters of close study and it is most gratifying to note the general appreciation of this effort. Some success has been attained in the endeavor to create an impression of light and cheerfulness. The walls generally are



Nurses' station, showing annunciators

Dressing cubicles, x-ray department



Fluoroscopy room, with linoleum flooring

in ivory shades and each floor has a different pastel color for the ceilings which are all textured. The higher floors have lighter, cooler colors, while those on the lower floors are a warm buff; from the third floor upward they are finished in soft azure blue and silver green tones.

Light fittings and furnishings were all specially designed to complete a harmonious whole and to maintain the spirit of modern hospital development.

The problem in the x-ray department was to provide new housing for activities that are ever growing in diagnostic and therapeutic value. For twenty-seven years the x-ray had been used in the hospital and, by 1935, it was endeavoring to cope with 24,000 patients per year in a hopelessly inadequate area.

The hospital board decided to build a new x-ray block, and a site was chosen for convenient access to in-patients and out-patients. The form of the block, a single story with basement, was dictated by the need for preserving maximum light to the ward block, which it adjoins. A flat roof is available for the patients of this ward block.

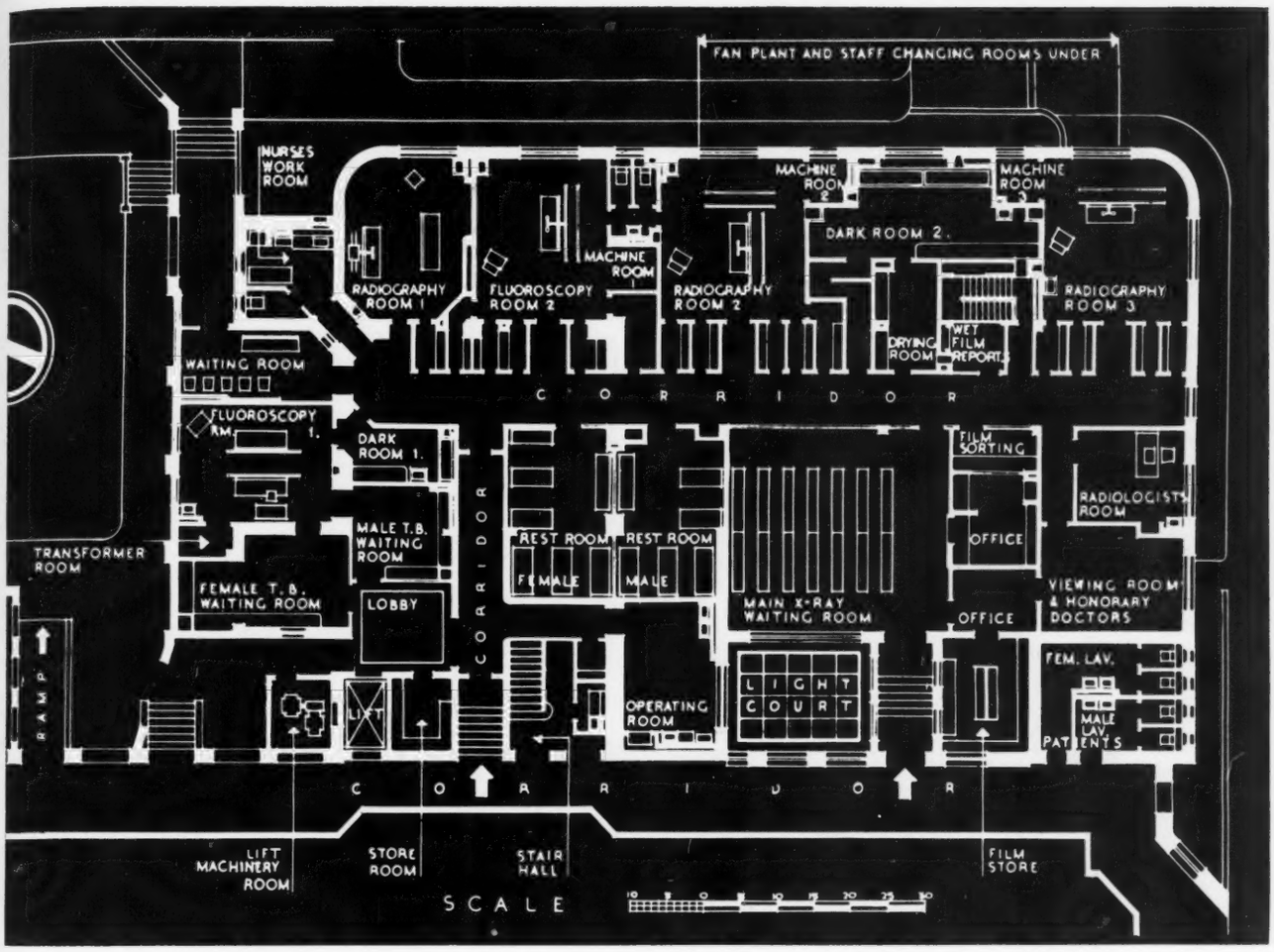
Owing to the large unbroken area on one floor the provision of natural light has presented a problem that has been overcome by the use of pavement lights in the flat roof, and of glazed screens instead of solid partitions whenever possible in the department itself.

The accommodation provided is three radiography rooms, two fluoroscopy rooms and an operating room. Separate waiting rooms and entrances are provided for public, paying and tuberculous patients. Stretcher cases or patients that need rest after treatment are provided with special rest rooms.

An attempt has been made in planning to provide a logical sequence of circulation. The inquiry desk is convenient to the main waiting room and to the offices and viewing room. From the waiting room an ambulant patient goes to one of the dressing cubicles adjacent to the particular room in which the x-ray exposure is to be made. Cubicles are of flush paneled wood veneer and are furnished with mirror, seat and coat pegs. Two or more cubicles are provided for each x-ray room. From the cubicle the patient passes directly into the x-ray room.

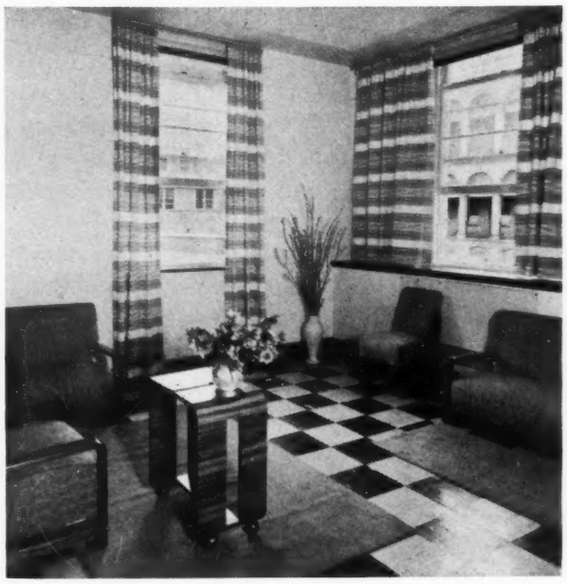
Here in two of the radiography and one of the fluoroscopy rooms the most modern of German machines have been installed. Existing machines are being used in the other two rooms for the present.

Cassette pass boxes are provided in each of these rooms, and the dark room is easily accessible. From the dark room films pass to the film drying



A complete and separate unit is the x-ray block, which adjoins the ward block.

cabinet, thence to the sorting bench and viewing room. A small room is provided for previewing wet films where the radiologist can check the film before the patient leaves the x-ray department. The construction is of reenforced concrete with external cavity walls of red brick to harmonize with the existing structures. General finishes are similar to those used in Gloucester House.



Corner of the attractive main waiting room.

Elimination of sound, provision of heating and color have all been considered in the design, and these contribute to the comfort and pleasure of both operatives and patients.

A balanced system of ventilation is supplied to all the main rooms. Radiation is provided by a hot water system with which flush ceiling radiators are used throughout.

To minimize noise the ceilings of the public waiting rooms and rest rooms have been covered with sound-absorbent plaster and the floors are covered with heavy linoleum. All partitions are insulated by sound-absorbent material from the floor; the x-ray room walls are also insulated from the penetration of the x-rays.

Colors used are brighter than in Gloucester House, for the patients' stay is shorter. In the public waiting room the steel frames of the windows and tubular frames of the seats are a bright red-orange, the backs of the seats being black laminated plywood. Furniture was designed by the architects to combine utility with harmony.

Far-Away Island Hospital

By RAYMOND P. SLOAN

AN ISLAND 30 miles at sea, lying south of the elbow of Cape Cod! There you have it—merely a pin dot on the Atlantic Ocean. The letters are plainly discernible on the map—"Nantucket." The name covers a county, an island and a town in Massachusetts, and gets its derivation from the Indian, meaning "Far-Away Island," or "Land-Far-Out-at-Sea." To thousands of passengers on the great transatlantic steamships who search eagerly for the rays of the lightship off the treacherous Nantucket shoals it means home.

Surely the stranger who travels seaward by plodding steamer from New Bedford or Woods Hole on a day when the ocean is made petulant by brisk breezes will not question the statement that 30 miles lie between the island and the mainland. The "Islanders," too, before the advent of the Nantucket Cottage Hospital in 1911, were made acutely aware of the remoteness of their island home whenever illness befell them and they were obliged to travel for hours over rough seas to obtain the hospital care they needed.

Laboratory

A second look at the map reveals this far-away island as measuring some 14 miles in length and 3 miles in width. As if to compensate for its exposed location, nature has placed the Gulf Stream near by, thus assuring it milder winters and cooler summers than corresponding latitudes on the mainland. Nantucket in consequence has been enabled to establish and to maintain a reputation as a health resort.

This is fortunate indeed, for little remains of the industries that won for it wealth and reputation 100 or even 200 years ago. No longer are the masts of old whalers to be seen lining the docks. The larger fishing interests have removed to New Bedford because of better shipping facilities. And instead of supplying candles to almost the entire world, Nantucket today must rest content to accommodate hosts of tourists who infest every nook and cranny of the island, satiating their thirst for historical data by invading such special shrines as the Elihu Coleman Homestead, the Whaling Museum and Maria Mitchell House. The winter population of 3,000 jumps to between 10,000 and 12,000 when vacation season rolls around.

So many historical places are there to visit that the presence of three gray shingled cottages on West Chester Street means little to the average visitor as he rushes past in quest of the "oldest house," which stands on the hill beyond. Built directly on the tiny sidewalk, their entrances up a short flight of steps from the street, they are fairly typical of Nantucket architecture. Flower boxes filled with bright petunias extend a welcome, and white trimmings are as fresh and shining as the face of a small boy just scrubbed.

Should he meet with misfortune, however, become ill or break a leg in his explorations, the chances are that the stranger will become conscious of the fact that these modest little buildings house a modern hospital, and that even here on a wind-swept island out in the Atlantic he will find medical and surgical facilities as complete and up-to-date as on the mainland.

The history of Nantucket Cottage Hospital goes back to 1911 when a group of public spirited men and women joined to form a hospital association. As long as we are living in the spirit of the past and are in the mood to examine old documents such as those we find in the Historical Association, let us read "An Appeal for Our Island Hospital" signed by one of the original trustees.

"For nearly 250 years this island community has been an exemplar of human brotherhood in

You have to look twice to distinguish the Nantucket Cottage Hospital from the other little gray shingled houses that line West Chester Street. It has twenty beds and five bassinets and a well-equipped operating room.

the best definition of that term. Its aged poor are well cared for; whenever known, man's necessity is, at all seasons, the neighborhood's opportunity. Almost every year the sea takes its toll on these coasts, and the dead and dying are cared for by the community. There has been no house of refuge. Only two years ago last March the bodies of men, frozen and freezing, were brought over from Great Point, fifteen miles distant by land and nine by water, to the town, and there was no hospital to receive them.

"Within the last six months we have been enabled, through generous help and united effort, to buy a cottage which shall serve this purpose. In order to begin and maintain this noble work on an island in the Atlantic 30 miles distant from the mainland, there is urgent need for an endowment fund of $100,000. Many of the 3,000 permanent population are fishermen, and the little community as a whole is not able to bear the extra burden of hospital maintenance.

"I have faith to believe that the thousands of Nantucket's descendants, who have an ancestral interest in this Island Outpost of our United States, will be glad to give to this endowment fund, if only they may know of the need for it.

"I have faith to believe that so soon as this urgent need shall be generally known, the thousands of strangers who come to this island for the summer months will give, in glad recognition of rest accorded them here, of relief from physical pain obtained here, of health restored in this marvelous climate, to this fund which is to maintain a cottage hospital in a sea-enclosed community.

"It may be, also, that the tens of thousands who pass annually the South Shoals' Lightship, off Nantucket, on their passage to and from Europe, may give, in appreciation of what that first and last signal means to them—home and native land —a thought to the little island just beyond the shoals, and with the thought—a gift.

"And besides the many who, for personal reasons—as a thank-offering for health restored or as a memorial for some beloved—may wish to contribute to this endowment fund for our island hospital, I have faith to believe that among the ninety millions of our United States, there are some thousands who will feel it a privilege to

further this good work which, in truth, is but the laying of one more foundation stone for that kingdom of heaven which we are permitted to establish only on this, our earth.

"It is in this faith that, through the courtesy of the press, I make the appeal for our island hospital."

Thus, thanks to a group of friends, the Nantucket Cottage Hospital sign was first hung outside a single gray shingled house on West Chester Street, the oldest thoroughfare on the island. Obviously it was not built for a hospital so all sorts of exigencies had to be met. Since that time new sections have been added with connecting passages, and there stands today an efficient little hospital plant with accommodations for twenty beds and five bassinets and as attractive an operating room layout as can be found anywhere.

An island hospital, particularly an island hospital so remote, conjures up all manner of difficulties from the standpoint of administration. Yet it is not as difficult as it may at first seem. Supplies are brought by boat throughout the year from New Bedford. Airplanes, too, have proved a godsend, particularly in emergencies.

Only last spring or early summer, newspapers throughout the country reported a shipping strike on the Nantucket boats and drew lurid pictures of an island cut off from supplies and rendered helpless in the midst of the Atlantic Ocean. Yet in reality nothing more serious than inconvenience was suffered by the Islanders. Food stuffs and all necessary supplies were transported by plane from the Government Naval Base, and life went on in its usual leisurely fashion. Modern science makes complete isolation impossible.

Probably one of the first questions that would be asked of the superintendent, has to do with help. "If we on the mainland find labor a problem, what about you who are 30 miles out in the ocean?"

Is There a Labor Problem?

Let us consider the nursing situation first. Nine graduate nurses are employed, including an operating room supervisor. These girls come from New Bedford and other points on the mainland and soon adjust themselves happily to life on the island. There are also nurses married and maintaining homes on the island who are glad to help out in emergencies. Recent graduates are paid $77.50 a month with maintenance for the first six months, after which they are raised to $82.50. At the end of the first year this is increased to $87.50 with one month's vacation.

The hospital in return for service rendered has all manner of people working for it. Anybody who has anything the hospital wants can make some arrangement to work out his bill. Carpenters, truckmen, taxicab drivers—all at times have paid off their accounts in this way. Women frequently will come in and work for a day or two, but the regular routine is handled by full-time employees.

The hospital started with one doctor in charge. It now has an open staff with five doctors using its facilities in winter and six in summer, the extra man being a summer resident. The major part of the work comprises surgery and obstetrics. Each year, particularly each summer, brings an increasing number of broken bones and other accidents. July and August are the busiest months.

All Island Babies Hospital-Born

All the island babies are born in the hospital. Last year there were fifty-eight and this year up to the middle of August there were forty-nine. There is a flat rate for maternity cases of $45 for ten days, although during the winter months rates generally are reduced. At this time of year private rooms range from $4 to $7; semi-private, $4, and ward beds, $3.

There is just one clinic, for tuberculosis. This is held every two months. Once each year, however, the state department of health sends its representatives to the hospital for a week. These include a nutritionist, dentist, doctor and nurse who, in conjunction with the school nurse and public health nurse, examine all children of preschool age, from six months to six years.

The interest that certain citizens evinced in the work of the hospital at its inception has carried through the years. Its progress could not have been so marked or its services so thoroughly recognized had it not been for the support of the men and women on its board, some of them Islanders who moved to the mainland years ago and have now returned to spend the rest of their lives enjoying the peace and quiet the island offers. Through their efforts the endowment has now reached almost $200,000.

Other larger hospitals might well take a lesson from some of the by-laws that govern this board. Each trustee is elected for a three-year term. There are fifteen members in all—men and women who are year-round residents and summer visitors.

Each week a house committee of three meets at the hospital, a different group coming each time. Each month the trustees meet. They discuss various problems with the superintendent, inspect the building if they desire to do so and are made aware of the hospital's problems. A finance committee of three also meets at least twice a

month. Hospital trusteeship in Nantucket carries with it distinct obligations, which are for the most part taken seriously.

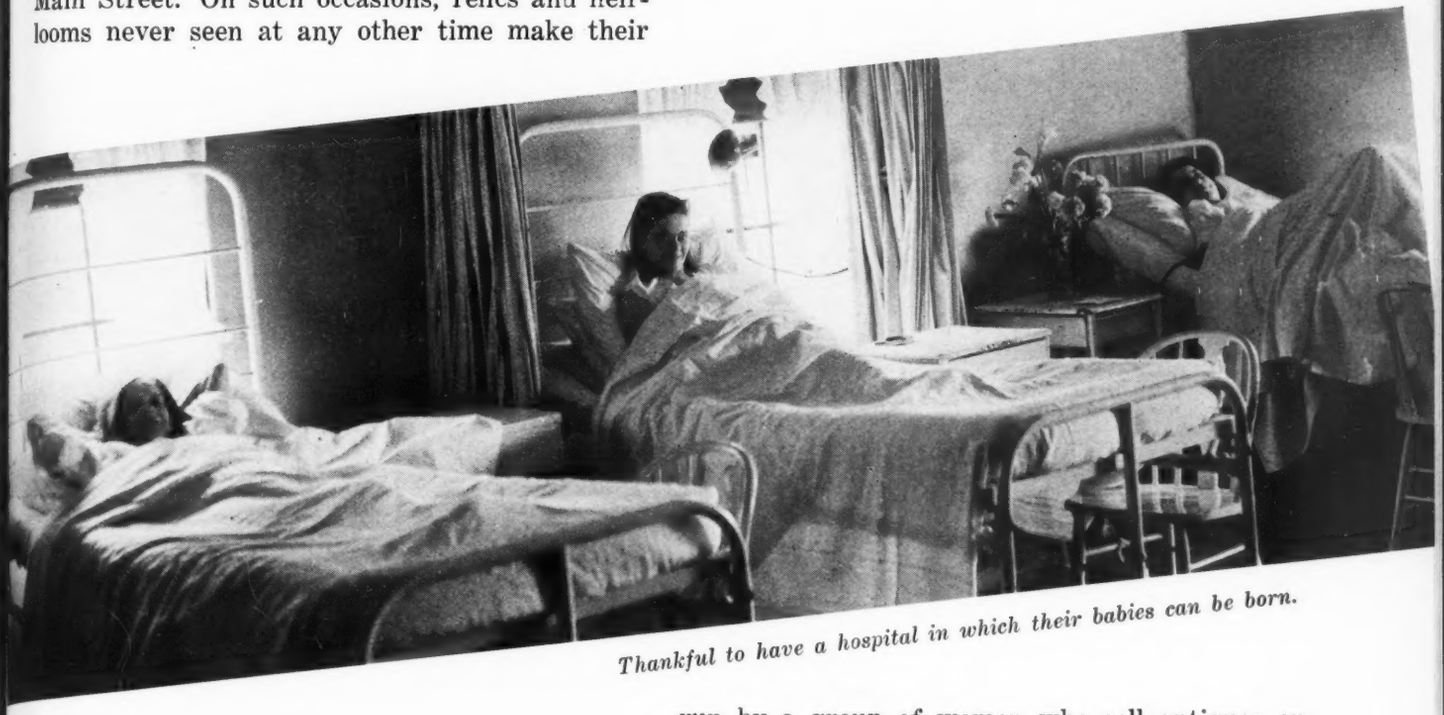
This interest in hospital work on the island permeates the entire summer colony each season when hospital week rolls around. Attention is directed to this event by signs conspicuously placed urging donations. This last season $19,000 was raised, most of it from a house-to-house canvass.

Then every other year or so comes the great fair, which is now a Nantucket institution. Boats to and from the mainland carry thousands of visitors who mingle in the gay throng that jams Main Street. On such occasions, relics and heirlooms never seen at any other time make their appearance in exhibits staged in the old houses. Into the bottom of dust-covered chests hidden away in attics the Islanders dig down for old costumes with which they adorn themselves. The elders, fantastically garbed, sit in the doorways; the youngsters, similarly attired, bob in and out of the crowds selling flowers and souvenirs. Along the wharves artist members of the summer colony lend atmosphere. Surely it would not be Nantucket without the artists! For a surprisingly small sum they will paint a portrait, draw a caricature or cut a silhouette. It is a gala occasion, representing weeks of work—all for the benefit of the Cottage Hospital.

In this way the yearly deficit is met. It is not large, generally $7,000 or thereabouts. Anything left over is used for modernization—new equipment and renovating—for damp winds and mists work their vengeance upon wooden buildings. In addition to the annual drive, the town takes care of those needing hospitalization to the extent of $2,500 each year.

Gifts, too, come from the women's auxiliary, another manifestation of community interest in the hospital. There are twenty-five or thirty women who gather frequently and raise funds for special needs. Last year, for example, they furnished the operating room with a new lighting system. Every Christmas they arrange a party for the children. Most of these women are winter residents.

Then, downtown on one of the historic streets that run into Main is the Thrift Shop. This is run by a group of women who sell antiques on commission as well as other articles that are donated. A percentage of these sales goes to the hospital.

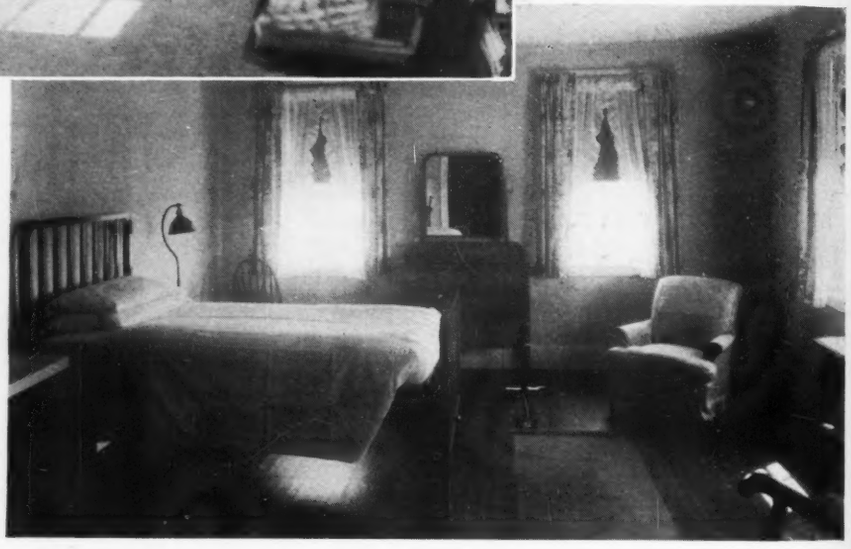


Thankful to have a hospital in which their babies can be born.

This spirit of friendship carries through on the hospital's contacts with those it serves. Every patient as he leaves is handed a slip of paper bearing the name Nantucket Cottage Hospital. "We are both anxious and willing," he reads, "to improve the service that this hospital tries to give to every one of its patients. If you have a helpful suggestion to make, will you not assist us by writing it down on the lines below.

"Also, if you have found that the hospital service has met with your entire satisfaction during your stay here, will you please tell us so on the lines below."

Six women and one man, aside from nurses and superintendent, carry on the work of the hospital. The man does odd jobs about the buildings, serves as orderly, attends operations and makes himself



From the main entrance a sun-flooded reception hall (above) leads to the hospital proper. Private rooms (right) are typically Nantucket—simple but airy, sunny and pleasantly homelike in atmosphere.

useful generally. Then there are a dietitian, a cook, a kitchen maid, a maid in the nurses' home and a maid on each floor. A secretary in the office takes care of admitting and of the visitors and answers the telephone.

A technician is now employed the year round. Anesthesia is given by the operating room supervisor.

And who would ever dream of the town photographer as x-ray technician? Yet that is precisely how it has been worked out in Nantucket. The gentleman in question was sent away for a course of study in hospital x-ray examinations and is doing an excellent job; last year he made 300 of them. He is always available for hospital service either day or night.

Summer days at Nantucket have their charm, but those who know it best love it most at Christmas when devoid of the need for entertaining "paying guests" the island can settle back into its quiet charm. At the hospital, too, there is less activity, permitting ample time for holiday festivities.

With the spirit of Christmas in the air, then we will leave it. Downtown on Main Street the shop windows are ablaze with lights and the frosty air bears the music of Christmas carols. Along the street leading to the hospital the tiny houses are dotted with electric candles in the windows. Within the gray shingled cottage that bears the name Nantucket Cottage Hospital are the spicy scent of pine and the hustle and bustle of happy preparations.

Suddenly is heard a weak little cry. A child is born, not in a manger as that other baby whose birthday we are celebrating, but in a modernly equipped delivery room of the modern cottage hospital on "Far-Away Island."

Subcutaneous Oxygen Therapy

By M. HERBERT BARKER, M.D.

THE great increase in the understanding and use of oxygen in a large number of clinical problems has led to the development of many types of equipment for its administration. Many old and new companies are launching into a field that is still in its infancy so that institutions and physicians interested in oxygen therapy are offered many instruments with only slight variations in style or construction. However, the need for simplified and inexpensive devices for administration of oxygen has popularized the nasal catheter, the oxygen box-tent of Burgess and the face-tent by Campbell and, more recently, by Barach. The same demands have caused to be produced instruments for subcutaneous administration of oxygen.

Because of repeated questions from various institutions and physicians, a brief summary of our research and clinical observations* with subcutaneous administration of oxygen seems to be justified.

Efficiency of Method Is Tested

The efficiency of oxygen given subcutaneously has caused much discussion since Bayeaux made his first machine for its administration. Experiments carried out in this laboratory designed to evaluate some claims may be of interest and they will be reviewed briefly.

Dogs were placed in a constantly conditioned chamber where the normal oxygen saturation of 20.96 was gradually reduced so that the surrounding atmosphere contained only from 3.5 to 5 per cent oxygen. This reduced the blood oxygen content as much as 60 per cent, resulting in severe anoxia. Marked cyanosis, labored respiration and finally collapse and death of the animal resulted unless the oxygen content of the chamber was increased or unless the animal was allowed to breathe normal air. Even in states of asphyxial acidosis and extremis, the animals immediately regained consciousness even after from four to ten respiratory excursions in normal air.

However, when these animals were rendered similarly anoxic to various degrees as measured by arterial blood desaturation they showed no symptomatic relief or any elevation in the blood oxygen content when oxygen was introduced under the skin. Because of the looseness of the dog's pelt and its scant blood supply, attempts to reach a richer blood supply were made by intramuscular injection. No relief of anoxia or change in the arterial oxygen desaturation could be measured. The inhalational method was immediately restorative, thus emphasizing this route for the treatment of systemic anoxia.

Not a Substitute for Inhalation

Another series of experiments in rabbits and dogs was designed for a check on claims made that antibody formation, precipitin and agglutinin were stimulated by the subcutaneous administration of oxygen. A long series of critical observations made in this laboratory by Youmans and Simpson failed to show any change whatever. This work will soon appear in the *Archives of Internal Medicine.*

The experimental evidence for the subcutaneous administration of oxygen thus causes one to be critical of the numerous claims made from uncontrolled observations. Certainly, the subcutaneous route is not to be substituted for the inhalational methods now in use for systemic anoxia until more convincing evidence is gathered.

However, the subcutaneous method may be an adjunct to those methods as indicated by the occasional case in which severe anoxia persists even with the inhalational method operating at full efficiency as illustrated by the following case:

Report of Case: Miss S. K., a 38-year-old stenographer, was seized with a right lower lobar pneumonia. She was seen on the third day of the disease and placed in an oxygen tent with 50 per cent oxygen concentration. A relief of dyspnœa, restlessness, distension and a decrease in pulse and temperature followed. However, the disease process spread to the right middle and left lower lobes. The oxygen saturation of the tent atmosphere was increased to 70 per cent and transfusions were given sufficient to maintain the red cell count over 4,250,000. Finally on the ninth day of the disease, the left upper lobe became involved and the patient's pulse, respiration, temperature and distension went beyond control and she appeared in

*This work was made possible by a grant from the council on physical therapy of the American Medical Association, a liberal supply of oxygen by the Linde Air Products Company and instruments by the Oxinjector Corporation.

extremis. At that time from 8 to 10 liters of oxygen were injected under the fascia lata bilaterally. This made the legs quite distended and tympanitic below the groin to the knees. The patient's great need and the fact that the oxygen was under firm pressure of the fascia lata no doubt facilitated the burrowing of the oxygen into the muscle substance where absorption could take place. Whatever the mechanism may have been, the oxygen so placed was rapidly absorbed so that another 10 liters were injected into each thigh every three to four hours.

The dramatic relief in the patient's dyspnœa and pulse rate following each injection with a return of the symptoms as the subfascial tension began to fall caused us to continue the treatment for four days at which time she was enough improved to be able to carry on with the tent alone. She recovered.

We have had another similar case in which so much lung surface was involved that finally large volumes of subfascial oxygen were given in addition to the inhalational method. Again, enough symptomatic and clinical improvement was noted that all of us in attendance were convinced of its real importance. To rule out the whole benefit as being due to the subfascial oxygen, the inhalational method (nasal catheter, 14 liters per minute) was discontinued and the patient showed immediate evidence of asphyxia and the catheter flow was resumed.

These clinical observations speak for the benefit, if not life-saving value, of subfascial oxygen in large doses in those cases in which the inhalational deficit has resulted in systemic anoxia of such a severe degree that asphyxia is imminent. Experimental work in animals either by hemorrhage or anoxia shows clearly that, although ordinarily there is a great margin of safety, when the critical point of anoxia of the medullary centers is reached, a sudden failure of the respiratory center follows. Similarly these experiments show that even a small reinfusion of blood in the case of hemorrhage or an increase of the oxygen saturation by 1 or 2 per cent in the case of severe anoxia will restore the animals. Our clinical experience suggests the importance of meeting this danger point at the edge of the margin of safety.

Oxygen to Combat Gas Gangrene

Another important point is suggested by two experiences with gas gangrene. Oxygen injected freely around the field infected with the gas bacillus has caused an apparent arrest of the process as others have reported. One of the cases is worthy of comment in this regard:

Report of Case: V. B., a healthy boy, 16 years of age, fell off a pier and caught the right inner aspect of the thigh on a rusty, protruding piling spike. The wound was quite deep and bled freely and a local physician sewed it up about four p.m. By midnight, the boy was very ill with rising fever; crepitus was easily felt around the injured area. A surgeon opened the closed injury and removed all of the traumatized tissue and left the area opened widely. Large doses of antitoxin and local applications of potassium permanganate did not alter the vicious progressive course of the disease. A brown watery discharge continued to pour from the area and the crepitus spread toward the right groin. The boy's temperature and pulse continued to rise for the next three days.

At that time, a needle was introduced about 6 inches above and below the open infected area and 300 cc. of oxygen were injected subcutaneously and into the muscle layer involved. The gas infiltrated rapidly and was seen to spread in all directions and bubbles came out into the open incision. Within three hours' time, the discharging fluid had turned from a brown watery color to a clear fluid, which rapidly decreased in amount. The color of the exposed muscle turned from a brownish to a more normal pink color. Injections of oxygen were made every four hours of such volume as to keep the inner aspect of the thigh from the inguinal region to the knee very crepitant. The wet packs were discontinued so as to leave the open surface exposed to the air except for a cradle and a sheet. Within twenty-four hours the patient showed marked improvement and recovery followed.

After watching the rapidly progressive picture of this gas bacillus infection until oxygen was injected under the skin in liberal amounts, one could not resist the feeling that the procedure had saved a life. So dramatic was the change in the local picture together with systemic improvement that one would feel that every institution and every physician coming in contact with gas bacillus infections should consider the continued use of oxygen given into the involved tissues.

Stimulates Tissue Growth

One other group of patients have been benefitted by injections of oxygen. Full thickness skin grafts in which blood supply has not been well maintained, are benefited by intracutaneous injections of oxygen into the flaps that are embarrassed. Similarly crushing injuries to the skin and deeper tissues of elderly persons whose circulation is poor have been clinically aided by saving of tissue and by the promotion of repair by the liberal and regular injection of oxygen into the healthy tissues about the injured area. Oxygen so injected burrows freely in all directions. Whether the oxygen is absorbed by the cells directly or by the blood vessels in the area is not known at present.

To summarize, experimental studies indicate that the subcutaneous administration of oxygen is not a substitute for the inhalational methods now in use. No experimental evidence was found for the theory that subcutaneous oxygen increases antibodies or agglutinin and precipitin reactions. Clinical observations suggest that subcutaneous oxygen may be of great benefit in extreme cases of anoxia if given subfascially in large amounts as an adjunct to the inhalational methods. Local injections of oxygen may be helpful in skin grafts and in traumatized tissues in which the circulation is poor. A case of gas gangrene is reported in which the local injection of oxygen was regarded as a life-saving therapeutic measure.

Out-Patient Operating Costs

Income and Outgo in 174 Hospitals

By MARGARET LOVELL PLUMLEY

IN THE accounting systems of hospitals provision is seldom made for recording separately income and expenses of the out-patient department from that of the sponsoring hospital. Some hospitals record only the receipts from out-patients and make no mention of facilities and services contributed by the hospital proper. Only a few set up accounts in such a way that both direct and indirect out-patient department expenses can be ascertained. Salaries may constitute the sole recorded item of expense, notwithstanding the fact that the aggregate value of space, supplies and utilities contributed by the parent hospital may represent a large proportion of the true operating costs.

The significance of the foregoing general statements is illustrated by the returns from a country-wide study of out-patient departments conducted in 1936 by the U. S. Public Health Service as part of the National Health Inventory. Of 769 hospitals found to operate true out-patient departments, only 174 were in position to supply the type of data necessary for analysis of income and expenditure.

General Service Predominates

Four-fifths of these 174 departments were located in cities with populations of 100,000 or more. More than one-half were located in New York, Philadelphia, Chicago, Pittsburgh and Baltimore, and of these the great majority were in the first two cities. Except for size and location the departments used in this study are fairly descriptive of all organized out-patient departments. Seventy per cent were connected with community hospitals supported and controlled by nonprofit agencies. Those attached to hospitals operated by local and state governments followed in declining order. Departments providing a general service predominated; 80 per cent were of this type. The remainder were special departments operated for the most part by tuberculosis sanatoriums and by hospitals for children.

An out-patient department usually has two main sources of support: receipts from patients and an allotment from the general funds of the hospital. In the early days of out-patient department work the amount collected from patients was so small that practically the entire cost of operation was, of necessity, paid by the hospital. The data at hand reveal that the situation has changed. In the group of departments on which this study is based, receipts from patients covered nearly 40 per cent of the reported expenditures.

TABLE I—PERCENTAGE OF EXPENDITURES DEFRAYED BY INCOME FROM DIFFERENT SOURCES FOR OUT-PATIENT DEPARTMENTS OF 174 HOSPITALS

Control and Type	*Number of Dept.*	*Total Exp.*	*Per Cent Expenditures Defrayed by Income From Specified Sources*			
			Patients' Fees	*Tax Funds*	*Gifts*[1]	*Deficit Made Up by Hosp.*
Total	174	$8,628,607	38	11	12	39
Government						
General	18	1,212,753	14	51	3	32[2]
Special	7	69,459	2	75	—	23[2]
Nongovernment						
General	120	6,459,325	43	4	11	42
Special	29	887,070	42	2	31	25

[1]Including income from endowments and community chest contributions.
[2]Tax funds.

The percentage distribution of income is presented in Table I. The allotment from hospital funds appeared most frequently to represent a deficit made up by the hospital rather than an amount budgeted in advance. In only nine instances was the total income reported by the hospital for out-patient department use in excess of the total expenditures.

Receipts from patients in the government departments covered only a small proportion of the total expense. Slightly more than 85 per cent of their income was derived from tax funds, either

appropriated specifically to the department or allotted by the sponsoring hospital to make up the deficit. Gifts and contributions to tax-supported departments were negligible. Only three departments, controlled by state university hospitals, reported income from this source. Forty-three per cent of the total sum received by departments or nongovernment hospitals, on the other hand, was made up from patients' fees. Gifts and contributions constituted 14 per cent and appropriations by taxing bodies, 4 per cent. Deficits amounting to 39 per cent of total costs were defrayed from general funds of the parent hospital.

TABLE II—TOTAL VISITS, TOTAL EXPENDITURES AND AVERAGE COST PER VISIT FOR 174 OUT-PATIENT DEPARTMENTS ACCORDING TO SIZE OF DEPARTMENT

Size of Dept.	*No. of Dept.*	*Total Visits*	*Total Exp.*	*Cost per Visit*
All sizes	174	10,581,700	$8,628,607	$.81
Under 10,000 visits	44	204,487	297,659	1.46
10,000-24,999 visits	36	619,091	565,714	.91
25,000-49,999 visits	29	1,011,560	879,504	.87
50,000-99,999 visits	29	2,048,061	1,862,774	.91
100,000 visits and over	36	6,698,501	5,022,956	.75

The departments attached to hospitals rendering only specialized types of service reported nearly three times as much income, proportionately, from gifts and contributions as the general departments; consequently, the amount of the deficit to be made up from hospital funds was smaller for the attached special departments.

The unusual measure of the expense of outpatient department operation is the cost per visit. Table II shows the average cost per visit for the departments classified according to size, together with the reported visits and expenditures which form the basis for this calculation. Unit costs appear to decrease as the departments increase in size. The class with the highest average cost per visit, $1.46, consists of the smallest departments, those reporting less than 10,000 visits. The lowest average visit cost, 75 cents, was found for the largest departments, those with 100,000 or more visits. This figure is influenced to a considerable extent by the low costs (44 cents) reported by ten government departments. In contrast, the average cost per visit for the twenty-six nongovernment departments was 87 cents. The combined average for all size groups was 81 cents.

A wide range in cost per visit was disclosed by examination of the figures of individual departments. The lowest reported was 21 cents and the highest, $4.48. At the lower end of the range were twenty departments which gave visit costs of less than 50 cents and at the upper end were thirteen, by which corresponding unit costs of more than $2 were reported. The small departments of special hospitals appeared to be the most expensive to operate, possibly because of fewer patients, more frequent use of special diagnostic and therapeutic procedures and greater development of social service. Exceptions to this general rule were found, because in every group were individual departments that reported unusually high or low unit costs. Nevertheless, 80 per cent of the forty-four smallest departments reported visit costs of over $1, less than one-third of the departments in the next higher interval and only one-fourth of the largest listed as high a figure.

The 174 departments under consideration were grouped according to visit costs and the characteristics of each group were studied. Table III presents the picture for income and expenditure. Three classes were utilized: those with visit costs of less than 75 cents, those for which costs ranged between 75 cents and $1.50, and those with costs in excess of $1.50. Fifty-seven departments fell into the first class, of which nearly 90 per cent were general and, for the most part, controlled by nonprofit agencies including churches. Receipts from patients covered 38 per cent of the total cost of operation, tax funds 22 per cent and gifts and contributions, 8 per cent. The costs per visit ranged from 21 cents to 74 cents. About one-third of the departments reported costs below 50 cents.

TABLE III—EXPENDITURES AND INCOME BY SOURCES OF 174 DEPARTMENTS GROUPED BY VISIT COSTS

Cost per Visit	*Total Dept.*	*Total Receipts*	*Per Cent Income Derived From Specified Source*			
			Receipts From Patients	*Tax Funds*	*Gifts*[1]	*Deficit Made Up by Hosp.*
All costs...	174	$8,628,607	38.4	11.0	12.1	38.5
Under $.75	57	2,459,301	38.5	22.3	8.2	31.0
$.75-$1.50	93	5,514,013	38.8	6.0	12.9	42.4
Over $1.50	24	655,293	34.1	11.3	20.0	34.7

[1]Including community chest contributions and income from endowment.

The largest number of departments was found in the second class, those with visit costs ranging from 75 cents to $1.50. Ninety-three departments reported costs within these limits. Nearly four-fifths were general; almost all of them were under government control. The proportion of cost covered by receipts from patients was essentially the same as for the less expensive departments. Relative portions provided by gifts and by tax funds

were reversed for the two groups, however. Hospitals were required to meet a greater deficit when visit costs were in the middle range than when they fell in higher or lower priced brackets.

Twenty-four departments reported costs of more than $1.50. Fourteen of these were special departments of which all but four were clinics attached to tuberculosis sanatoriums and children's hospitals. Patients' receipts were 38 per cent of the total expenditure for the nongovernment departments and only 2 per cent for those under government control. Twenty-two per cent of the expenditure for the nongovernment group was defrayed from gifts and contributions, almost all of which were reported by the special departments. The proportion of income from tax funds recorded by the nongovernment group was negligible. Nine of the fourteen special departments reported a cost per visit of more than $2. Only four general departments were as high.

All except six of the 174 departments reported on the established policy with regard to fees charged per visit. Sixty per cent of the out-patient departments in the reporting group of government hospitals and 4 per cent of those under nongovernment control accepted all patients free of charge. Rates stated by the others ranged from less than 10 cents to more than $2, but four-fifths of them charged less than $1. The more common rates were 25 cents, reported by fifty-two, and 50 cents reported by fifty-seven departments.

Twenty-five departments charged $1 or more, only six of which reported fees of more than $2. Of the thirteen charging exactly $1, one included laboratory tests, two were departments of special hospitals which reduced fees for those unable to pay, and the other ten either operated a definite sliding scale or stated that fees were reduced or remitted for those unable to pay. Four of the twelve charging more than $1 were either pay clinics or else accepted anyone regardless of his financial status. Two reported that the fee covered the cost of x-ray and physical examination. Four of the others stated that 70 per cent or more of the visits were free. All except one reported either a sliding scale or considerable flexibility in the size of the fee charged. Of the 129 departments charging fees and reporting the proportion of free visits, two-thirds stated that more than 50 per cent of the visits were free.

From a nationwide study of out-patient departments conducted by the Division of Public Health Methods, National Institute of Health.

Ruining a Racket

By JOHN A. BOYKIN

FIRMS and corporations in Atlanta, Ga., had been harassed by unfounded damage suits over a period of several years before a group of business men finally organized to combat this racket. At a meeting of these business men it was agreed that all suspicious damage suit cases or claims and all evidence indicating that such suits or claims were fabricated should likewise be reported. A citizens' committee was appointed and a fund raised to investigate thoroughly every reported suspicious claim.

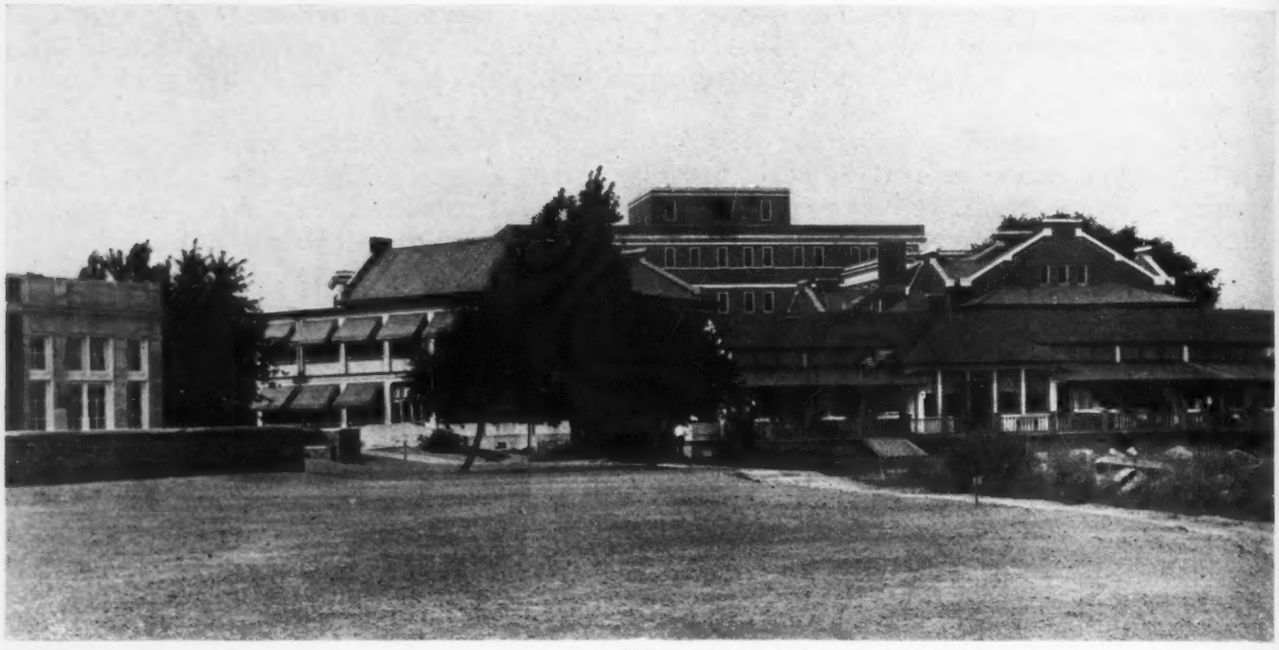
It would have been impossible for the citizens' committee to accomplish all that has been accomplished without the cooperation of the Southeast Index Bureau. Through its facilities, the bureau can determine whether or not any particular individual is filing a large number of suits. A person racketeering in fake damage suit claims often becomes plaintiff in a number of cases and also claims. Equally often he files a number of suits and claims under fictitious names.

All claims are compared, as are the witness lists. It is often found that the same person filed all of the claims, and used the identical list of witnesses or a list of witnesses controlled by some other racketeer in the same line. We found an interchange of witnesses, an interchange of lawyers and an interchange of doctors.

We found that the most effective way of checking fake damage suits is to require each person to file the claim in his own handwriting, and for witnesses to write their statements in longhand. If they refuse to do this, we take their deposition immediately before a commissioner and there have them write for the purpose of comparison.

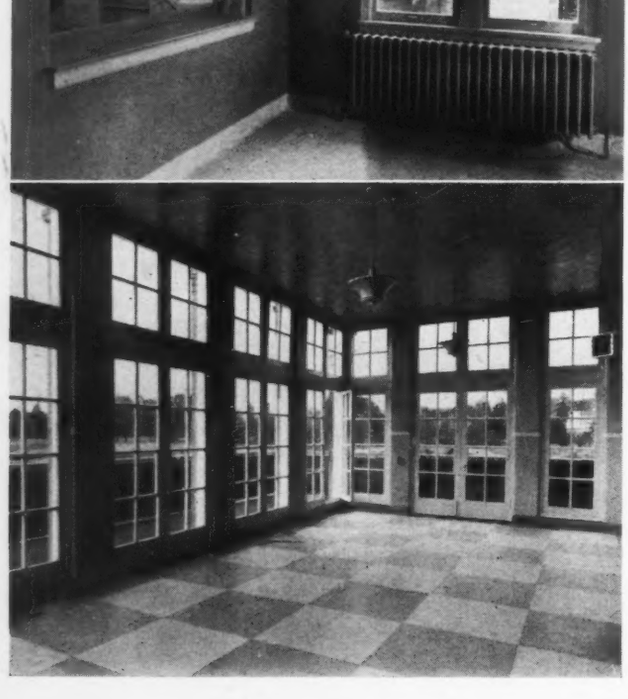
We have tried and convicted twenty-one persons, among them lawyers, witnesses and procurers of fake damage suits. We have two doctors under indictment. Up to this time, we found that these same doctors appeared in many damage suits and that one of them issued as many as nineteen false certificates.

The investigation is proceeding cautiously but thoroughly. Only one person who has been tried up to this time has been acquitted. Thorough preparation and careful procedure are essential.



Three views of the new tuberculosis hospital at Toledo, Ohio.

New Sanatoriums Seek the Sun

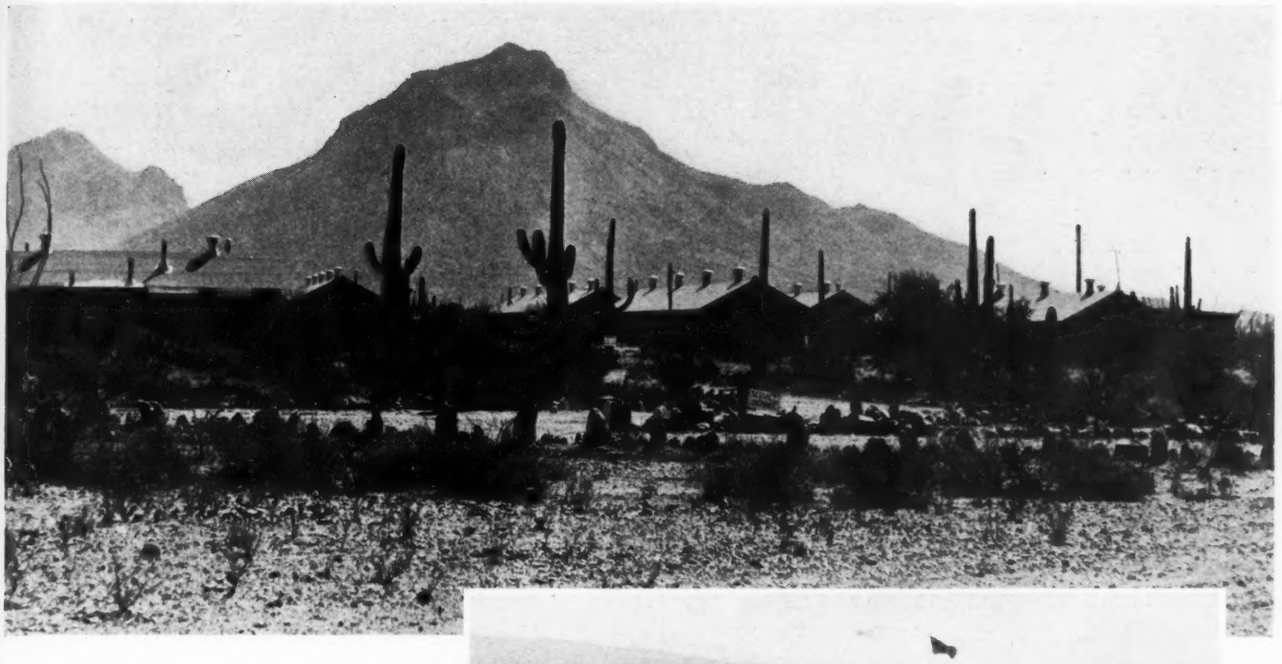


By HOWARD WHARTON

DESIGNED to relieve the case load and overcrowding of tuberculous patients in certain communities as well as to provide preventorium facilities for cases not yet in the virulent disease stage are the tuberculosis hospitals, sanatoriums and camps being constructed by the Works Progress Administration in various sections of the country. All of these projects were sponsored by local groups who were aware of the need in their community for more adequate facilities adapted to wider ranges of treatment and care of tuberculous cases.

The William Roche Memorial Hospital for Tuberculosis at Toledo, Ohio, is one of the largest units of its kind to be constructed by the WPA. Cost of the hospital is approximately $700,000.

Thousands of dollars were saved in the construction by the use of salvaged materials obtained from the demolition of buildings on and about the site of the new hospital. Materials such as bricks, lumber, steel trusses, glass, building stone and piping were donated by the various owners represented. Their cooperative spirit was typical of the whole community.



Third in a series of articles on hospitals constructed by WPA

Preventorium at Tucson, Ariz.

The building designed by Frank Lange, Toledo architect, is a single story structure with the central section in the shape of a T. Extending from each end of the T are open Y-shaped wings that house the incipient or ambulatory patients. Thus there are six wings in all extending from the three ends of the T building. The appearance of the complete structure is that of three Y's extending in three directions from the main section that houses the entrance and administrative offices.

The main section, or T, consists of the head, 307 feet long by 40 feet wide with the vertical leg, 45 feet long by 40 feet wide. The wings extending off each end at an angle of 45° are each 159 feet long by 44 feet wide.

The open, extended nature of the design ensures the maximum amount of sunlight possible to each ward. A sun deck, 6 feet wide, on which the patients may be placed on warm sunny days, circles the entire building.

The design permits segregation of the patients according to sex, age and stage or degree of their infection. Since tuberculous persons are highly susceptible to psychologic influences, it is felt that by proper segregation of advanced and incipient cases a better mental attitude will be induced and recovery of certain cases thus made more rapid.

The men's and women's divisions are each complete with 14 four-bed wards, 6 two-bed rooms, 2 three-bed rooms and 20 rooms available for either single or two-bed use.

The children's department comprises 14 four-bed wards, 6 two-bed rooms and 4 single isolation rooms. In addition to having service facilities duplicating those contained in the men's and women's wards there are facilities for the care of those cases afflicted with tuberculosis of the bone. Part of this equipment is an ultraviolet ray lamp. The hospital will house 300 tuberculous patients.

The administrative quarters contain four examination and treatment rooms in which minor operations may be performed. Isolation rooms, entrance rooms, a matron's office, clothing, drug storage and service rooms complete these quarters.

To eliminate the construction of new cooking units the structure was connected with the main building of the Lucas County Hospital, on the same grounds, by a tunnel large enough to permit the passage of heated food carts. Thus only serving rooms are necessary in the new hospital.

Simultaneous with the construction work on the new hospital another WPA project was carried on to determine the extent of tuberculous infection among the school children of Toledo. Staffs composed of two nurses, a physician and a clerk visited the schools and applied the Mantoux test to the children. Tests were given only after an approval slip was signed by their parents.

Figures available show that out of 19,299 children examined, 3,082 showed positive reaction. Positive reaction to the test in most cases does not mean active tuberculosis. In the majority of cases it means only that there has been a contact in the past, perhaps an infection years before which is now healed over. A roentgenogram is necessary to show if the disease is active.

It has been the purpose of these tests not only to determine the extent of infection but also to awaken a public consciousness to the needed care of children who have or are contacting the disease. The new hospital provides care for the exposed child and also isolates and treats the actual victim.

Two Projects in Colorado

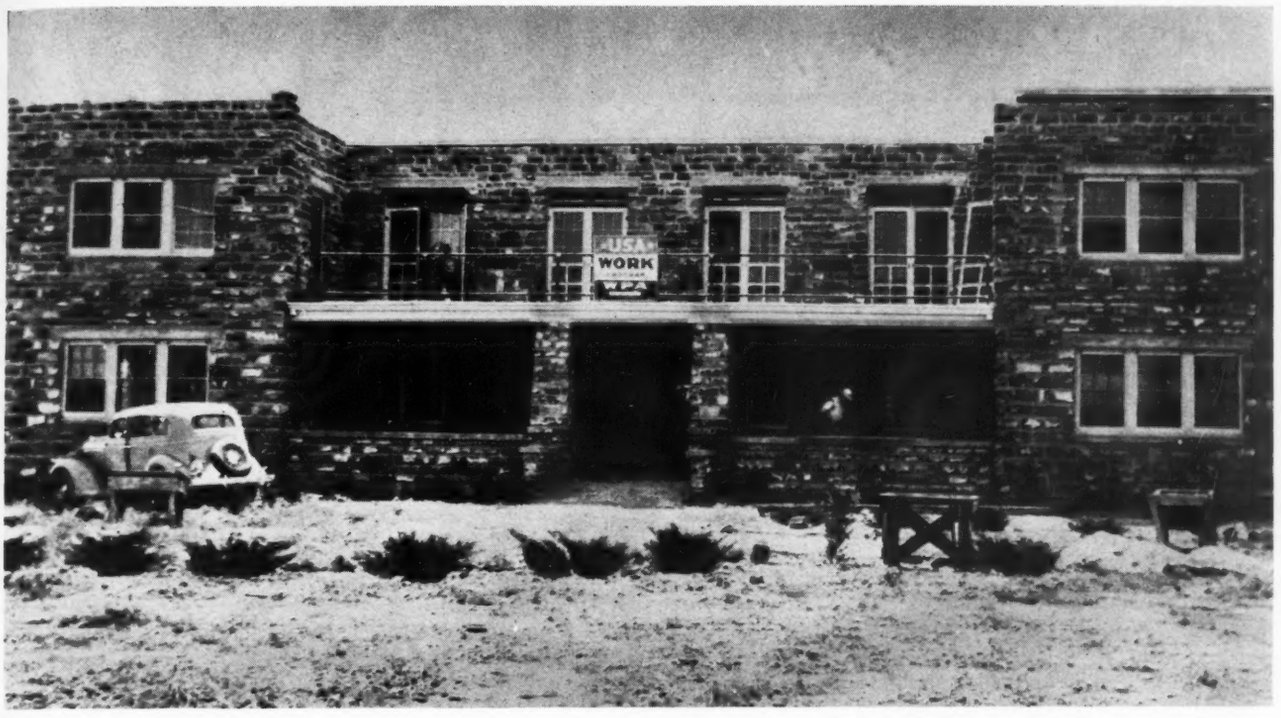
Another sanatorium built by WPA is located at Lamar, Colo. Designed to assure the proper care of indigent tuberculous patients of Prowers County, the hospital is constructed of red native sandstone pointed with black mortar. The stone was quarried near Lamar.

The sanatorium is two stories high and has facilities for thirty-six persons with auxiliary arrangements for four more. The building is divided into seventeen rooms, including four private rooms, five wards, four bath rooms, kitchen, dining room, examination room and nursing office. Each of the interior partitions was also built of red sandstone. Hardwood floors are laid throughout and the walls are finished with plaster wainscoting.

Window space is extensive throughout the building, thus assuring sunlight in every room. The building was designed to permit placing a sun platform over the large front porch. The cost of the completed project was approximately $27,000.

Gateway and main façade (below) of the G. B. Cooley Sanatorium at Monroe, La., constructed with funds from the WPA.

In Colorado, in addition to the Prowers County Tuberculosis Sanatorium, pictured on the opposite page, a laboratory exclusively for research in tuberculosis has been built on the campus of Colorado College, Colorado Springs.



Prowers County Tuberculosis Sanatorium, at Lamar, Colo.

A complete laboratory operated by the Colorado Foundation for Research in Tuberculosis has just been built by the WPA on the campus of the Colorado College at Colorado Springs. It is one of the few laboratories of its kind devoted exclusively to research in tuberculosis.

The laboratory contains 3,000 square feet of floor space divided into twelve rooms: monkey room, guinea pig and rabbit quarters, five individual laboratories, x-ray, spectrographic room, photographic and dark room, director's office and cleaning and sterilizing room.

The animal quarters provide rooms for the housing of thirty monkeys and 100 guinea pigs. An air conditioning system supplies the animals continuously with filtered air of the proper temperature to keep them healthy and also to aid in eliminating unpleasant odors.

Walls and ceilings of the laboratory space are constructed from fireproof wall board while the floor is of asphalt tile. The animal quarters have cement floors and plaster walls to facilitate cleaning. The five individual laboratories are separated by glass partitions to permit sufficient isolation without prohibiting simultaneous supervision of experiments in the other rooms.

Rooms for radiation research are located along the blind wall of the building. The laboratory has its own generator for spectroscopic research and light therapy. The x-ray room provides facilities for theoretical research and for taking of x-ray pictures of monkeys to follow the course of the disease in these animals.

The WPA spent $2,775 in constructing the building, while the local sponsors furnished part of the material and contributed $6,108 to cover the cost of the necessary technical equipment.

District of Columbia Has Camp

Nearing completion at Washington, D. C., is a preventorium for the care of curable cases of child tuberculosis. Designed to accommodate 125 children the construction of the camp was financed by a grant of $79,000 from the WPA. Equipment is to be furnished by the District of Columbia.

The need of such a camp to restore to health children who show a tendency toward tuberculosis is essential to the District of Columbia. Figures show that the death rate from tuberculosis in the district is one of the highest in the United States. The present rate of deaths is 106.95 per hundred thousand population.

The new camp will consist of three dormitories, mess hall, infirmary and administration building. One dormitory will house white boys, another white girls and the third, colored boys and girls. Quarters for the staff will be provided in the administration building.

The dormitories each 130 by 21 feet provide ample porch space for sun baths. Segregation of the children into semiprivate wards is possible by the means of movable screens.

Recreational facilities will be provided for the children in the mess hall, and athletics and games will be part of the daily routine under the supervision of the nursing staff.

With the Roving Reporter

First Aid to Efficiency

• That is a unique floor medicine cabinet that George D. Sheats, superintendent, Baptist Memorial Hospital, Memphis, Tenn., is proudly showing to visitors these days. Step up and have a look. Unfortunate that we cannnot all inspect it personally, but here is a photograph which the Roving Reporter submits for your examination. Even at first glance you recognize it as a valuable first aid to efficiency.

The cabinet itself is square, approximately 24 inches deep, 25½ inches wide and 6 feet 4 inches tall. These are the outside measurements. In the middle of the cabinet is a vertical rod

approximately 1½ inches in diameter. Around it are arranged circular shelves, each shelf being divided into eight divisions, and each division taking care of a room. It becomes a simple matter to prepare the medication for each patient's division, thus eliminating all chances of error. The cabinet is illuminated, with a door switch control so that when the door is opened it lights the cabinet.

Prowlers Beware

• Every now and then we read in the papers of some daring robbery staged in a hospital or of invaders who prowl with no good intent about the nurses' home. It wasn't more than a year ago, for example, that May Middleton of the Methodist Episcopal Hospital in Philadelphia received due tribute in the local press for bravely routing bandits after they had held up her cashier. And surely a lady hospital superintendent wielding a gun at retreating bandits is front page stuff!

Anyway, Presbyterian Hospital in Chicago has made things difficult for these unwelcome visitors. The sight of stalwart police officers on duty, one by day and two by night, is sufficient to discourage the bravest invader. It is their task to patrol the hospital within and without, ensuring adequate protection to patients and nurses as well as to cash and valuables.

That most vulnerable spot, the cashier's office, has received special treatment. It is fully equipped with burglar-alarm wiring, the cashier's window fitted with bulletproof glass and the other windows barred on outside and equipped on inside with bulletproof mesh. The only entrance to the office has two doors, each fitted with bars and bulletproof glass and never opened without a policeman in attendance.

Let's penetrate a bit further. The burglarproof safe, in which most of the cash on hand is kept, is located within a vault. Both vault and safe are equipped with combination locks, the combinations being known to only a few persons. In addition to the hospital funds, money and valuables belonging to the patients are kept in the safe. Deposits in the bank are made promptly, and the money is transported from the hospital safe to the bank in charge of armed guards in an armored car.

As a further protection to residents in the nurses' home, fire escapes are equipped with burglar-alarm wiring and exits are constructed so that they can be opened only from the inside.

Have a "Coke"?

• No danger for anyone in New Orleans suffering from thirst, either within hospitals or without, as long as the supply of Coca Cola holds out. Take the stranger who enters Touro Infirmary, for example. He's hot, and he doesn't care who knows it. His mouth is dry and his throat is so parched that every swallow is an effort. But wait, is that a Coca Cola sign he sees in the Coffee Shop? Immediately he takes heart, steps up to the counter and forgets his troubles.

Life has its compensations, even for those who must visit the out-patient department, bringing with them also a thirst. It may be nervousness; it may be the heat; what matter! From where they sit their eyes feast on a machine that dispenses mysteriously long cool drafts of the same popular beverage.

Believe it or not, Touro is using at the present time between 900 and 1,000 cases of Coca Cola a month. There are several reasons for this rather unusually high beverage consumption in a hospital, Dr. A. J. Hockett explains. "In the first place, the city of New Orleans has a very high per capita consumption of Coca Cola. Most staff physicians order it almost routinely on all postoperative cases, because of its caloric content; also, it has a slightly stimulating effect. The beverage is said to provide something like 70 calories per bottle."

Four Coca Cola stations are provided in different parts of the hospital. The Coffee Shop serves patients as well as visitors. Then there are three slot machines. There accrues to the hospital some $250 net profit each month from Coca Cola.

Via the Mail Route

• Nothing like getting to know your patients, particularly when the hospital is a small one. It furnishes an insight into their problems and reveals possible causes of dissatisfaction. The Day-Kimball Hospital, Putnam, Conn., has fifty beds, so the plan originated by A. K. Fulkerson, superintendent, when he was business manager, has worked out well.

Every morning he would deliver mail personally to the patients and take that opportunity to chat with them for a few minutes. "They're always glad to see the postman," he says, "and it provides an excuse for a few minutes' conversation, during which much valuable information can be gathered regarding the family, whether the patient is satisfied with the service he is getting, and if there are any complaints, what they are and how they can be adjusted."

Today Mr. Fulkerson, because of his administrative duties, is not able to make rounds with the mail. He makes rounds just the same, at least once each day, to be assured that his patient family is as comfortable as possible. It is a matter of regret to him that he cannot personally play postman. "You are always assured of a warm welcome," he reiterates.

Liaison Officer

Correlation of health and welfare services is necessary for the best interests of the public

By MARY WYSOR KEEFER

IT IS in the capacity of liaison officer between health and welfare that the medical social worker can bring to the state a real contribution. The medical social worker does not focus upon medical or upon social problems separately, but upon the area where these two become interrelated. Hers is an individualized service to sick persons in social difficulties. She is trained to study and treat the social problems related to illness. With this specialized training she should be able to work out a correlation between health and welfare services that is now, for the most part, lacking.

Under the social security act, the U. S. Children's Bureau has developed a program that gives recognition to the importance of the correlation of services. Before a state can secure a grant-in-aid from the federal government for aid of crippled children or for maternal and child health, it must submit a plan which, among other requirements, provides for the cooperation of medical and surgical treatment, nursing care, welfare service and educational facilities.

Two Fields Overlap

The Children's Bureau has expressed its belief that a maternal and child health program to be successful must be founded on a generalized service and that an integration of public health service and social service is essential. Nurses will follow up crippled children after they are discharged from the hospital and social workers will assist in determining financial need, developing plans for boarding or convalescent care, interpreting the case to the family and utilizing social resources.

The fields of the public health nurse and the medical social worker overlap in that each is concerned with problems associated with health. Their duties do not duplicate but rather complement each other. The nurse's central focus is upon health and her method is education; the focus of the social worker is upon the social aspects of health and she concentrates upon the study and treatment of social maladjustments related to all types of illness and chronic disease.

To determine whether or not social workers should be concerned with the prevention and control of chronic disease one need only read some of the questions asked in a study being made by the U. S. Public Health Service. What is the volume of chronic disease in the general population of the United States? What is the age and sex distribution of these diseases? Is occupation a factor? Nationality? Unemployment? Housing, with reference to crowding? What disability is caused by chronic diseases? What economic problems are associated with it? How is chronic disease cared for? To what extent are the facilities now available to the sick being used in different types of communities? Are more facilities needed, and if so, what kind of facilities?

The medical treatment of chronic disease alone is insufficient and economically wasteful. What is the use of providing medical care and buying insulin for a diabetic mother when there is no money for a special diet? A correlation of medical and social treatment would avoid much waste. The function of interpretation of medical social problems and correlation of medical and social services in the community has already demonstrated its value in states in which medical social service has been incorporated in the program of the department of health, as in Massachusetts and California. Experience has shown that the function and activities of the medical social worker in a public health set-up would come mainly under the classifications formulated by the New England District of the American Association of Medical Social Workers:

1. Act as liaison between the department of health and social agencies to include interpretation of public health policies to social agencies

and the policies of social agencies to public health groups.

2. Offer consultation on medical social problems to nurses, nonmedical social workers and others.

3. Advise individuals with medical social problems who apply to the public health departments as to suitable resources.

4. Organize and supervise medical social service in hospitals under the direction of the department, for example, tuberculosis sanatoriums or hospitals treating orthopedic conditions, cancer, contagious or chronic diseases.

5. Organize and supervise medical social service for clinics under the direction of the department, for example, syphilis, gonorrhea, tuberculosis, cancer, maternal health and child hygiene clinics.

6. Participate in educational programs of public health department—conferences and institutes—for professional personnel and lay groups where the subject discussed is medical social problems.

7. Assist in research where medical social factors are involved.

The medical social worker up to this time has operated largely within the walls of the hospital or clinic, but it is becoming ever clearer that she has a contribution to make toward community health. She sees at first hand the ravages of disease and the resultant social maladjustments. She can help to develop an informed public opinion.

Protecting the Nurse's Health

By GEORGE F. STEPHENS, M.D.

ANY health scheme for hospital nurses should commence prior to admission to the school. The preentrance physical examination should be thorough, and must cover the personal history of the applicant. The points of family history to be considered are epilepsy, mental disease and tuberculosis. The general physical examination should be supplemented by special examinations by a competent eye, ear, nose and throat doctor and an orthopedist. X-ray plates of the chest and a tuberculin intradermal test should be taken.

All details of the preentrance examination should be conducted by members of the hospital staff. They understand hospital requirements better than the family physician, who may not have maintained close contact with hospital practice.

Various immunizations must be covered, either prior to admission to the school, or while the student is in her probationary period. These include vaccination for smallpox, typhoid vaccination, administration of toxoid for diphtheria following Schick reaction, and scarlet fever toxin following Dick reaction.

Too much stress cannot be placed upon the importance of the annual physical review. Part of the procedure will necessarily consist of completion of a form. Chest plating and urinalysis may be done before the nurse reports to the examining physician. A complete file of records, including documents for the preentrance examination and immunizations, should accompany the nurse. Pathologic conditions disclosed at examination may be referred to the proper department.

Tuberculin skin reactions should be repeated annually. It will be convenient if recordings are made in parallel columns for comparison. Records should be maintained throughout. Certainly there is room for inquiry when the nurse who was tuberculin negative last year is now found to be tuberculin positive. Unless records are kept, such points may escape notice.

All the foregoing relates to prophylaxis. There should also be a well-defined system for care of sick nurses, covering minor as well as major conditions. A definite hour of the day should be assigned for reporting nonurgent conditions. The hospital has the right to insist that nurses report for consultations of a general medical nature or for small dressings. The hospital should appoint a physician to sick nurses. He may be paid in accordance with financial means. Minor emergencies, such as small burns and incised wounds, should be dealt with immediately.

There should be a nurses' infirmary located either in the nurses' home or the hospital for the care of minor conditions, such as upper mild respiratory infection. An infirmary should have a nurse definitely in charge and extra nursing must be provided for at peak load.

The adoption of a routine for handling ordinary consultations and minor surgical conditions does not mean that the nurse who is ill must wait until the proper hour for reporting. Acute temperature conditions and abdominal pain should be dealt with at any hour of the day. As a matter of practice, the care of this group is not a problem.

Trials of a Rural Hospital

How small country hospitals may maintain the same departments as large urban hospitals is convincingly told here by the head of the Willmar Hospital and Clinic, Willmar, Minn.

By A. F. BRANTON, M.D.

THE most outstanding difference between an urban and a rural hospital is in its human relations. In a rural hospital every case is a matter of interest to all the community. It is in this wide contact that hospitals can do the most good. If the hospital is giving the service, if its death rate is low, if within the four walls there is human kindness, simple, straightforward honesty and good care, it does not have to fear community criticism. But let the opposite hold true and the hospital soon finds a dwindling daily census.

Fortunately, the old fears of the rural hospital as a place "where they always operate" or "where people go when terribly sick" or "where death never takes a holiday" are vanishing. The public of the smaller communities is learning that examinations are made for preventive purposes, that patients do get well, that they have x-rays and laboratories and good nursing. Deceit, fraud, dishonesty and mystery have no place in rural hospitals for sooner or later these attributes are discovered and freely discussed.

The hospital is and should be a center of medical education. Mothers should be made to feel free to "run in" and have the baby weighed. By such intimate contact much good can come to the individuals, to the community health and to national problems. The superintendent and the nurses should be able to discuss hospital problems at parent-teacher association meetings, 4-H Club meetings, rural community clubs and in their social contacts. If the rural hospital would undertake to explain vivisection in its real light, for example, the antivivisection propaganda could be quickly and readily overcome. In health forums practical preventive medicine and modern hospital care could be presented in a most effective manner. Legislation concerning hospitals could be

At the junction of tree-lined avenues stands the Willmar Hospital, Willmar, Minn. Below, the sun makes pattern across the end of the reception desk.

much more easily accomplished by this direct public contact.

Small rural hospitals cannot afford to train nurses under present standards. Nursing schools in the smaller hospitals are going to be discontinued when these hospitals have definite assurance from the nursing profession that their needs will be satisfied. One small hospital that eliminated its training school in 1930 cut its nursing costs in half immediately, at the same time giving many more of its graduates employment and its patients excellent care.

The dietitian is a problem in the small hospital. The doctor in many cases works out the diet or leaves it to the head nurse. This problem could be solved if three or four hospitals within thirty or forty miles of one another would cooperate in employing a dietitian. The dietitian could divide the time equally among all the hospitals, working out the week's menus, taking care of special diets and, if something urgent presented itself, advising by mail or telephone. Many hospitals obtain foods and service from those who are indebted to them. With a properly trained person to suggest and supervise the use of these products, they could be used to good advantage.

A completely equipped laboratory is almost a necessity in modern hospital practice. In the small hospital the work is left in many cases to a nurse or the doctor or not done at all. It is possible to have a trained laboratory technician in almost every hospital. Charges can be increased to meet the additional expense and the technician's services also may be made available to all the doctors in the community.

Accounting has been a weak spot in many smaller hospitals. One small hospital that employed a certified public accountant to install a system of bookkeeping a few years ago has found his services invaluable in compiling annual records and statements for the hospital. This hospital has been able to determine costs by departments and other pertinent information. The hospital learned that it had provided 3,226 patient days of care in one year and had served 19,300 meals, an average of 55 a day. The maids ate 17 per cent of the meals; the nurses, 30 per cent, and the patients, 53 per cent. The actual cost per patient day was determined at $4.41. The food cost per meal was found to be $.12; the help, $.062, and gas, $.014, making a total cost per meal of $.196. The death rate was a little more than 2 per cent, with .06 per cent within forty-eight hours. It is valuable to know these things in a small hospital for this information can be used to explain the hospital's operation to the public. With that knowledge the public indulges in less false criticism.

Even the inside corridor leading to the clinic offices gets sunlight.

Hospital records, that bugaboo of all small hospitals, constitute an unsolved problem. The younger doctor receives training in record keeping. He can do much to instruct the older practitioner. No older doctor likes to see a younger physician surpass him. If the older doctor is shown some good charts that a younger doctor keeps, he will be likely to improve his records.

Physical equipment in smaller hospitals is improving. The provision of basal metabolism and x-ray equipment, the newer splints, anesthesia machines and physiotherapy equipment are becoming more and more the rule rather than the exception. But there is still much to be desired. Rooms have not had too much attention. Some small hospitals have begun to make their rooms more colorful and are giving them some variety. This has been attempted by colorful wall decorations, bright figured curtains, beds and dressers painted in soft colors and through the use of attractive bedspreads, which are no more costly than drab colors.

A special problem in all hospitals is the "doctor on the case." The life of the rural doctor is wrapped up in a most intimate way with those who serve with him and are served by him.

The rural doctor may keep abreast of the times through reading medical literature, postgraduate courses of county medical societies and numerous short courses at the universities. The realization of the medical profession that it must keep up with the progress in medical science has given physicians the opportunity to become informed on the newest practices.

A real challenge is offered the small hospitals in making new apparatus available to the doctor. When he wishes to carry out some new technique of professional care the hospital should be ready to assist him. The hospital need not follow every fad, but when articles come into general use, they should be at hand.

Rural hospitals should have a place in the hospital field by becoming active members of the

national and state associations. National Hospital Day can be as well observed in small communities as in the larger cities. Smaller hospitals should be urged to respond to requests coming from recognized authority for help on legislative action. They may take part in convention programs and read and contribute to hospital literature.

When the American College of Surgeons succeeded in raising the standards of the surgeon and achieved gratifying results, it found that the surgeons needed a better workshop and that the hospitals needed similar standard-raising. Some rural hospitals were able to meet the minimum standards of the college. Others are trying to bring their affairs up to this standard. The small hospital has been helped to a marked degree because of this interest in them and the public is beginning to understand their value.

All small hospitals would, I am sure, welcome investigations of their methods by the American College of Surgeons or the American Hospital Association and the resultant suggestions for improvement by application of modern hospital administrative techniques.*

*Adapted from a paper presented at the sectional meeting of the American College of Surgeons, St. Paul, Minn.

How One Hospital Controls Curettage

By H. COPPINGER, M.D.

TO CONTROL curettage in the Winnipeg General Hospital, Winnipeg, Canada, it was agreed that reasons for performing the operation should be divided into four groups. Curettage, with or without dilatation, or any operation for the induction of labor before term, either by passing instruments, giving drugs or other remedies or means, is controlled as indicated:

1. Routine, *e.g.* a remedial therapeutic act, as distinguished from that of evacuation of the contents of a pregnant uterus, or incomplete abortion.

In all cases in which the attending physician, surgeon or gynecologist decides that a curettage is part of the treatment, it is necessary to fill in a form to be signed by the person who is to perform the operation, embodying the following information; name, age, married or single, date of last menstrual period, diagnosis and reasons for the treatment. The form must be submitted to the superintendent of the hospital for his information and permission.

2. For evacuating the contents of the uterus for incomplete abortion.

The procedure in this case is as above, except that a brief synopsis of the cause and onset must be recorded.

3. For evacuating the contents of a pregnant uterus for the termination of pregnancy as a therapeutic measure, or for inevitable abortion.

In this case a full and complete history of the patient must be taken and recorded, a definite diagnosis made and the proposed treatment or opinion of the attending physician, surgeon or gynecologist subscribed to in his handwriting and witnessed. If then, in his judgment, pregnancy should be terminated, a consultation with one or more physicians, surgeons or gynecologists must be held, and their opinions are recorded.

If, after consultation, it is decided to carry out the treatment, the husband, guardian or nearest relative must be advised, and his consent obtained and recorded. The recording of the consent may be waived in cases of persons whose religion does not sanction this procedure, and this should be noted on the case report. On completion, the case report with the opinions of the attending physician, surgeon or gynecologist and consultants must be sent to the superintendent of the hospital and his consent obtained before operation.

If, on consultation, the attending physician, surgeon or gynecologist does not agree as to the treatment and if the weight of opinion is against the original attendant, he may go to the court and receive the court's ruling and be guided by it, the hospital acting in accord with court ruling.

4. For the purpose of diagnosis.

In this case, the procedure is as in (1), and, in addition, the complete case report must be sent to the superintendent of the hospital for his perusal before operative procedure is carried out.

In giving or withholding his consent for such operative procedure, the superintendent is only safeguarding the hospital and does not assume any responsibility for the hazard of the case other than that pertaining to his office.

Ward Routines

By JOSEPH C. DOANE, M.D.

LAST month we discussed some ward procedures which might seem too commonplace to deserve description. However, in such matters as the administration of hypodermic medication, the catheterization and the irrigation of the urinary bladder and the irrigation of the colon, there lurk inherent dangers to the patient. These procedures are often performed carelessly and hence ineffectively. This article continues the description of routine ward practices.

A grant has been recently made to a hospital in the western part of the United States for the purpose of determining the most suitable bed pan for use in the hospital. Many may think the expense of such a study unjustified by the possible results. But there are phases of this problem that deserve comment. Many patients strenuously object to the complete bed rest which their condition demands because of the discomfort of the bed pan and their dislike for it. The patient suffering with coronary thrombosis or some other heart ailment must, of necessity, be kept at complete rest. The bedside commode or even the bath facilities attached to the patient's private room do not meet the doctor's demand for complete physical inactivity. Many patients find it impossible to use the bed pan satisfactorily. Others are so fearful and so fretful that there is scant choice between two evils—whether to allow the patient to walk to an adjacent bathroom or to require him to remain in bed.

The average bed pan, apparently because of its height, defeats nature's muscular mechanism for emptying the intestinal tract. With head and shoulders low and hips high a degree of physical strain is required which many physicians will agree has produced serious, if not fatal, effects in the case of the cardiac patient. Frequently very ill patients are permitted to use a draw sheet or the hospital may be equipped for such special use with a sharp nosed pan which does not require great physical effort on the part of the patient and which in some cases has been life saving.

Beds With Removable Section

Careful physicians and nurses insist on the presence of a proper pan and require the orderly or the nurse to be present to assist the cardiac patient, thus avoiding overstraining diseased heart muscles. A splendid but expensive method of helping the patient is to procure a bed equipped with a mattress having a removable section and a method of mechanically elevating the pan. Many well-built fracture beds are thus made. It would be a fine gift to any hospital to provide cardiac patients as well as those suffering with fracture of the spine or long bones with convenient and comfortable beds with bed pan appliances.

The bed pan room of the hospital should be separated from the utility room proper, should be artificially ventilated and should contain a warmer, bed pan sink, a washer or sterilizer and a bed pan rack. Enamel pans are satisfactory if they are changed often enough but in many institutions the bed pan equipment is disreputable in appearance and is unclean and insanitary because of chipped enamel. Stainless steel bed pan equipment is desirable. A separate bed pan for each private room is necessary.

Air or Water Mattresses Are Needed

Every institution must be equipped with a sufficient number of air or water beds. These are particularly necessary in the case of ailments in which trophic ulcers or bed sores easily form, in instances of extreme emaciation and in others in which inequalities in mattress surface produce discomfort to the patient. The air mattress costs usually about $25. It may be made of pure gum with a canvas covering or of a rubber impregnated cloth. It should be of high quality. It may be harmed by careless use of safety pins or by bringing it in contact with oily liquids. Air and water beds should not be kept in storage rooms which are overheated. It is probable that soon there will be perfected a more durable sponge rubber mattress to replace the equally or even more expensive air mattress. If a water mattress is used, the temperature of the water employed should never exceed 97° F.

Of all the necessities in a hospital ward in which surgical and medical patients are treated, an adequate method for elevating a patient in bed and maintaining him comfortably in a semireclining position ranks among the most important. Most hospitals have some of their beds equipped with Fowler springs, which should be built into the bed and not placed on the spring. Many have all of their beds so supplied. The use of detached back rests is rapidly becoming obsolete.

What is needed in the way of equipment for carrying on the everyday work of the ward nurse is told here in another article of this popular series

In the case of the cardiac patient and for the patient suffering with infection of the peritoneum this semireclining position must be maintained for many hours or days. Some wards are equipped with a heart board or rest consisting of an oblong wooden table with adjustable legs. This table placed astride the bed often has a semicircular area cut out allowing it to fit closely to the patient's body. It should be wide enough to allow for support of the arms.

Each institution should be equipped with an adequate number of fracture beds. These are not inexpensive but they are more convenient and efficient and less unsightly than the usual Balkan frame set-up. Such beds should be available for ward use and there should be one or more pipe frame beds for use in the private department.

Loading the Fracture Cart

The superintendent of the institution has repeated calls for the purchase of the newer types of fracture apparatus. It is advisable to create a fracture committee of the staff which will approve requests for new equipment. A standardization of fracture equipment will result in much saving to the hospital.

An ample supply of the basic necessities such as Buck's extension equipment, splints, rope, saw, screw driver, thumb screws, nails, brace and bits of various size always should be on the fracture cart. Splints and other articles required in the treatment of fractures should be stored in an orderly fashion in the hospital splint room and the key should be available at all times. Sometimes staff men are disgusted with the inability to obtain equipment when they need it. The splint room also should contain an ample number of crutches of all lengths. It is the custom of most hospitals to require a deposit of $1 or $1.50 for crutches when they are taken from the institution and to retain one-half of the deposit as a rental charge when the crutches are returned.

Hydrotherapy methods employed vary from the refined technique of the modern physical therapy department to the use of packs, sponges, bedside baths and the application of heat or cold by such methods as the use of the Liter coil or the sprinkle bath. In the absence of an organized department of physical therapy, a fine combination of physical and drug restraint can be practiced in the treatment of the delirious by warm and cold packs and in the reduction of fever by sponging at a temperature varying from 98° to 70° F.

Time was when the hospital physician immediately ordered morphine or some depressant drug by hypodermic when a patient became noisy or delirious. Now more often one uses the equally efficient hydrotherapy treatment. A sure evidence of a good and careful doctor or nurse is the type of care given to the body. Reference is here made to such necessary things as the relief of pain, the administering of a somnifacient and the ordering of enemas, catheterizations and proper feedings.

The various types of packs and baths used in the hospital are hot blanket pack, hot air bath, continuous bath, cold sponge, cold pack, chest pack and tub bath. These matters should be taught both to nurses and young doctors since the latter will frequently not have available the services of a nurse and often will be required to carry out these procedures themselves. Whenever water is employed in the treatment of patients protection of mattresses requires two large rubber sheets of good quality, a rubber pillow slip, a sufficient number of hot water bottles with flannel covers, a foot tub, an ice cap, utensils for holding hot liquids to use in the case of cold packs, a toilet tray, towels and face cloth. In the use of the cold pack not only can the principles of hydrotherapy be carried out but in the case of the delirious, such as in pneumonic patients suffering with alcoholic delirium, restraint is likewise possible.

Apparatus for Hot Air Bath

In each hospital there should be available apparatus for giving a hot air bath in bed. This apparatus should consist of a bed cradle, heated by electric bulbs which are so wired that there is no danger of burning the patient or causing fire. In many hospitals this apparatus is so cumbersome as to require the services of two or more nurses. This is unnecessary since there are on the market some efficient types of apparatus which make possible the administration of this kind of treatment with the least possible effort for nurses and attendants. All types of packs and baths are somewhat depressant and should never be given except under the doctor's direction and orders.

Fortunate indeed is that hospital having a con-

tinuous bath equipment. This treatment is routine in psychopathic hospitals but is a rarity in the average general hospital. It consists of a large tub with overflow attachment and with an automatically regulated thermostatic valve so that it is impossible to burn the patient. Persons in active delirium and psychopathic patients may be kept in a continuous flow tub at the desired temperature for hours or even days. Whenever this apparatus is used, it should be under the direction of a trained technician or at least of a nurse who has had special training since there is danger of drowning or burning.

The temperature of the water may be set at any degree desired but it generally ranges from 94° to 98° F. The Liter coil, which consists of rubber tubing cemented together in a ring, through which water at any temperature may be allowed to run, is a useful method of applying cold to the body.

Old-Time Remedies and Smells

Packs may be local as well as general. Preissnitz, who though not a physician, was knighted because of his accomplishments in the treatment of disease by hydrotherapy, gave his name to a cold pack, usually of the chest, which was used in cases of inflammation of superficial or deep structures. This type of treatment is seldom seen now but is one with which nurses and physicians should be familiar. Even in the absence of complicated apparatus and equipment, ward technique books should contain a description of these common methods of applying heat and cold in the treatment of disease.

No hospital exists that does not at one time or another find a necessity for the treatment of pediculosis or vagabond's disease. The skilled ward supervisor has at hand fishberry and other old time remedies for the prompt delousing of infected patients. Even in the best conducted institutions, eternal vigilance must be exercised in order to guard against the entrance of bed vermin. A frequent inspection of the living quarters of employees as well as of ward beds must be made, particularly during the warm weather.

The common method of treating inflammation of local, painful conditions by the application of counter-irritants is often clumsily if not incorrectly performed. Poultices, pastes, stupes, fly blisters and cupping comprise the procedures usually employed. Flaxseed, mustard and digitalis poultices are sometimes used. All are relatively simple methods of applying moist heat and ones with which the nurse should be familiar.

To prepare the digitalis poultice immerse digitalis or foxglove leaves in warm water until they are soft, using two ounces of leaves for each pint of water. Next, the water is heated to the boiling point and allowed to boil for fifteen minutes. The water is then drained and used in making a linseed poultice and the leaves are added before spreading the poultice on muslin. In days gone by this was applied to the kidney region in cases of renal disease. The mustard paste is often applied over the chest in cases of pulmonary congestion. It is employed in a proportion of 1 part of mustard to 4 or 5 parts of flour. The Tyson paste is a diluted mustard paste applied with a chest jacket which may be allowed to remain in place many hours.

Every hospital is redolent from time to time with the odor of turpentine stupes. This procedure is used particularly in the treatment of abdominal distention in the surgical or medical wards and requires a stupe ringer or stupe sticks, flannel cloths, muslin, turpentine, olive oil, an electric plate or some method of procuring heat, a chest blanket, an abdominal binder, a rectal tube and an emesis basin. In many institutions a large metal ring is securely fastened to the wall in the utility room to assist in wringing out the flannel cloths employed.

Fly blisters constitute another old-time treatment and are made of cantharides impregnated paper or muslin usually cut in squares of an inch or so. When applied for several hours to the skin this treatment produces a large blister. It is frequently employed in the treatment of inflammation of the pericardial sac and sometimes in other locations for the reduction of inflammation.

Without Apology

No mood is more contagious than that of uncertainty. If a request for permission to perform the postmortem examination is made in a faltering, hesitant and apologetic manner, one must expect it to fail. The physician himself must feel the importance of what he is doing, that he is rendering the family a service for which they can be grateful to him and to the hospital. Fortified by the conviction that in performing the examination a definite contribution is to be made to the progress of science and society, he can make his plea without subterfuge, intimidation or apology. Those who have a wide experience with such requests know how often the straightforward approach, neither aggressive nor hesitant, succeeds when any other would fail. Nowhere is the truth of the French maxim more evident: "qui s'excuse, s'accuse." — *Milton Plotz, M.D., Montefiore Hospital, New York City.*

PLANT OPERATION • • • •

Conducted by John R. Mannix and R. C. Buerki, M.D.

Controlling Fires by Sprinklers

By R. H. Petefish

FIRE prevention and fire protection in hospitals resolves itself into three distinct problems: (1) preventing the outbreak of fire; (2) preventing the serious spread of fire, and (3) providing for the prompt detecting and extinguishing of fire. Automatic sprinkler installations in hospitals constitute the most dependable method of solving fire prevention problems.

From a standpoint of construction, hospitals can be classified as fire-resistive and nonfire-resistive. Generally speaking, fire-resistive construction is defined as a building having masonry exterior walls and floors and roof constructed of reenforced concrete supported on structural members of reenforced concrete or steel properly encased in concrete. Nonfire-resistive buildings include all other types of structure, the most common of which are the ordinary wood-joisted brick buildings and buildings entirely of frame construction. The latter construction amplifies our problem of preventing the serious spread of fire.

Where Fires Originate

Work to prevent the outbreak of fire in a hospital is centered mainly in service areas such as laboratories, x-ray departments, kitchens, dining rooms, store rooms, laundries, paint and carpenter shops, maintenance rooms and janitors' closets. Approximately 75 per cent of all hospital fires originate in these areas and create the need for providing means of detecting and extinguishing the fire immediately.

The automatic sprinkler system is a device for automatically distributing water upon a fire in sufficient quantity to extinguish it entirely or to hold it in check in case the fire is located where it is impossible for the water spray to reach it. It consists of a series of pipes installed close to the ceiling to which sprinkler heads are connected at intervals of from 8 to 10 feet apart in both directions. These heads are made with a special solder which melts or a glass bulb which bursts at about 160° F.

Sprinkler heads have a ½-inch nozzle which, when opened, will discharge with force approximately 15 gallons of water per minute against a deflector that converts it into a heavy water spray designed to cover a floor area of from 80 to 100 square feet, depending upon the construction of the building. With such spacing of heads and their introduction into spaces under stairways, in closets, ventilating ducts and concealed spaces, there is little chance for a fire to gain headway.

Automatic sprinkler equipments are of two distinct types, namely, wet-pipe system and dry-pipe system. The wet-pipe system is designed to be used in areas not susceptible to freezing. This type contains water that is constantly under pressure and is therefore more certain of operation. The dry-pipe system is designed for use in unheated areas. The pipes contain air under pressure instead of water. It is so arranged that when a sprinkler head is fused and opened the air escapes and water is admitted automatically by the operation of a valve. This type of installation is more costly and demands more careful attention and maintenance. In hospital properties wet-pipe installations are more suitable, because in most cases all portions of the building are heated.

The cost of automatic sprinkler installations can be approximately estimated at 10 cents per square foot of floor area, depending upon floor construction and number of partitions in the building. This figure does not include the cost of water supply. As an example of cost let us assume a building 100 feet by 75 feet having four floors and a basement. The cost would be approximately $3,750. Adequate water supply, that is, a supply having sufficient volume and pressure, is mandatory to ensure satisfactory operation and performance of the sprinkler system. This supply can be from various sources, such as city water mains, elevated tanks and reservoirs provided with automatic fire pumps. Elevated tank and reservoir supplies can be utilized where the property is located outside of city fire protection or in areas where city water supplies are weak in volume and pressure.

Automatic sprinkler installations are an important factor in reduction of fire insurance costs. Insurance rates are made from schedules that take into consideration all details that have a bearing on the probability of a fire occurring; the probability of the spread of fire, and the probability of fire being extinguished without total loss. Automatic sprinklers are recognized by rating organizations as the most effective method of fire protection, and credit is allowed accordingly.

Insurance rates on hospitals without sprinkler systems are about two and one-half times the rate of those fully equipped with automatic sprinklers. Buildings with a partial equipment of

Fire-resistive buildings may be badly damaged by severe fires.

sprinklers are given credit for the degree of protection afforded.

The need of automatic sprinklers throughout a hospital building depends largely on construction. In a modern fire-resistive building with floor openings properly protected to prevent the spread of fire from one floor to another, automatic sprinklers are essential only in kitchens, x-ray and film storage rooms, boiler and fuel storage rooms and all other sections used for storage or service purposes. In buildings of the nonfire-resistive class, automatic sprinkler installation is imperative. Many hospitals are of light, flammable construction, having wood floor joists, floor openings unprotected and other structural defects which present serious fire hazards, especially from the standpoint of danger to life. Cost should not be considered.

A study of the fire record of hospitals and similar institutions in the United States indicates that fire occurs in such institutions at the rate of more than one a day and the annual property loss exceeds $1,000,000, which is of secondary importance when we realize that thousands of lives are endangered and many are lost. Only a few of the buildings in which fires occur are equipped with automatic sprinklers. The performance of sprinklers is uniformly good in controlling fires.

Through the installation of automatic sprinklers the best possible means of promptly detecting a fire is available by means of an automatic fire alarm system commonly known as water-flow sprinkler alarm. This alarm system can be either mechanical or electrical and will automatically transmit an alarm immediately upon the fusing and opening of a sprinkler head, thus simultaneously functioning as an alarm system and as a means of extinguishment. Alarm systems can be so arranged as to give an alarm locally and also to signal the municipal fire department, directly or indirectly. Proper maintenance to ensure faultless operation of a sprinkler system is important but not difficult. The care and supervision of the system should be delegated to someone in authority who should be held responsible for its condition, especially in keeping control valves open at all times. Sprinkler installing companies and fire prevention engineers are ready to assist.

The installing of automatic sprinklers in hospitals and similar institutions should be planned by competent fire protection engineers. Every individual institution presents a specific problem of prevention and protection.

Sprinklers should be installed in accordance with standards developed by the National Fire Protection Association. Before an equipment is installed, complete working plans should be submitted for approval to the insurance rating organization having jurisdiction. Automatic sprinkler work is a separate trade and the planning and installation should be entrusted only to companies with broad experience.

And Now a Necropsy Unit

By Frederick J. Winter

WHILE remodeling the autopsy room at Providence Hospital, Detroit, the thought came up of combining the usual individual pieces of equipment for autopsy room use into one unit. The photographs accompanying this article show the results obtained.

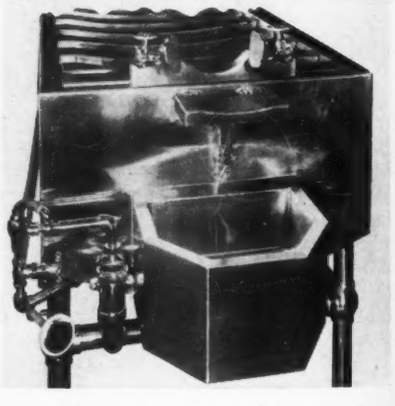
The table is 7 feet long and is built entirely of stainless steel. There are eleven crossbars on the top of the table and each crossbar is slidable and removable. This feature will permit the movement of the body after it has been placed on the autopsy table.

Under these crossbars the table bottom pitches to the center to a drain as shown. At the left is a surgeons' sink with knee-action control at the water supply. A work space also has been provided with a drawer below for instruments.

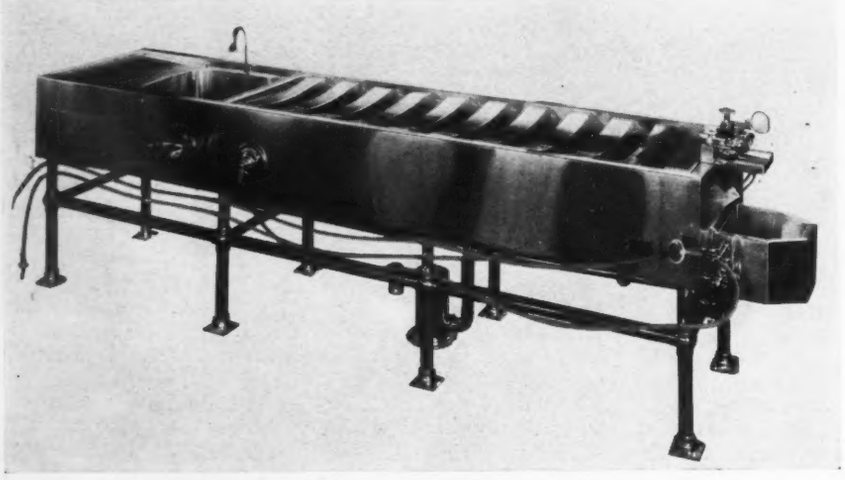
To the right of the sink is a mixing valve for controlling the long hose spray used for washing out the interior of the body. A suction device has been provided with hose and nozzle attached for withdrawing liquids from the body. The third run of hose is a compressed air line used for inflating certain organs after they are drained.

An electric convenience plug has been arranged for at the side of the table. The final feature is an adjustable head rest and clamp to permit operating in any position. There also is a head sink as shown.

Since this table has been constructed and put in use, an added feature has been designed in the form of a ventilating system consisting of pipes and manifold on opposite sides of the table below the crossbars, then down to and under the floor, across the room to a suction fan in an adjacent room. This ventilating system is for the purpose of withdrawing obnoxious odors.



Although the table was especially designed for Providence Hospital, and the work done by a Detroit concern, copies may be made, using the original drawings, at a cost of approximately $1,200. If a ventilating system similar to the one used with the table described is desired this item will add about $150 to the cost. If it is desirable to reduce the cost this may be done by omitting the surgeons' sink.



Autopsy unit with movable crossbars. At right, head rest and sink.

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Easier Reading for the Patient

By E. W. Commery

THE amount, quality and distribution of light in hospitals may be used so as to produce high visibility with comfort. They combine to effect a cheerful or depressing interior, or certain of these factors work singly or collectively to increase or decrease the nervous muscular tension, to retain the heart rate nearer to normal and to make seeing easier, thereby conserving energy and vision.

A room or a ward ideally lighted would likewise be ideal for the patient, for the benefits just mentioned are observable or measurable with the normal subject. They become even more significant to those who are ill or convalescent. Defective vision is aided proportionately more than normal vision with better lighting. May we not often look upon the vision of patients as being akin to defective? That alone will lead us to the most careful consideration of light and lighting, although this would in itself be a more limited point of view when the entire relationship of lighting and human beings is reviewed.

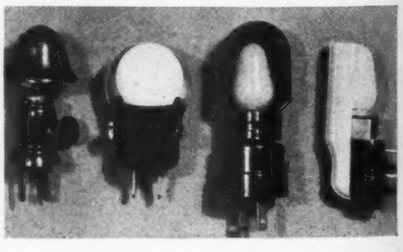
Since the walls and ceilings of an interior play an important rôle in the final lighting result, the finishes used on these surfaces need again to be reviewed. Glossy white has been used for a long time in hospitals, but this must be due to a point of view of efficiency. It does wash easily, it suggests cleanliness and it reveals a lack of it. When, however, it is seriously considered from the psycho-physiologic viewpoint, it is open to attack. In creating an environment for the patient it is strikingly unfamiliar, uninteresting and even ominous. The environment should bear some resemblance to that which is natural. This means the substitution of a reasonable degree of colorfulness for the unnatural whiteness. Cool or warm color schemes are readily utilized if the exposure of the room is to be taken into account.

Simplicity is definitely a ruling factor. With nature in mind, there is much to favor green for walls. However, the bluish greens are commendable and those which are softly grayed are to be favored. As a final check, the reflecting values of walls should be between 35 and 50 per cent. Since the ceiling is to be depended upon for a general distribution throughout the room, it will be considerably lighter. While the purest whites provide the highest reflecting value, some compromise is in order for the prone patient has the ceiling area in view a large part of the time. With this in mind "off-whites" such as cream tints are desirable.

While glossy finishes may not send annoying bright reflections to the patients' eyes in private rooms because of the favorable angles that usually exist in smaller areas, they are likely to strike the patients' eyes in larger areas devoted to wards. The avoidance of these disagreeable highlights, particularly from ceilings, may be assured through the use of the dullest paint finishes.

With the physical limitations imposed upon patients, reading usually becomes the chief diversion. Reading in itself may easily be considered as one of the more severe visual tasks and when it is sustained for any length of time much energy is used. This may be lessened or even minimized through the use of adequate amounts of light properly distributed. Today a recognized ideal is somewhat beyond the scope of simple, practical methods of solution. We, however, may make the start toward the ideal and in reviewing the standards involved greatly benefit the patient.

The plane at which a newspaper, magazine or book is held should have an illumination value of 25 foot candles or more. Furthermore this value should exist not only at the center of the page but should be measurable over the entire page. Lighting devices that meet this specification only can still be undesirable if they do not also provide lesser values of illumination beyond the confines of a page. Contrasts between the viewed page and the surroundings should be low, hence



Types of plug-in night lights planned to eliminate shadows.

the bed sheets and opposite wall need to be illuminated as well. Surroundings illuminated to approximately one-tenth of the value on the page usually provide for satisfactory conditions.

This means that the lighting device supplying the reading light should provide a broad spread of light to the book or paper and should also provide

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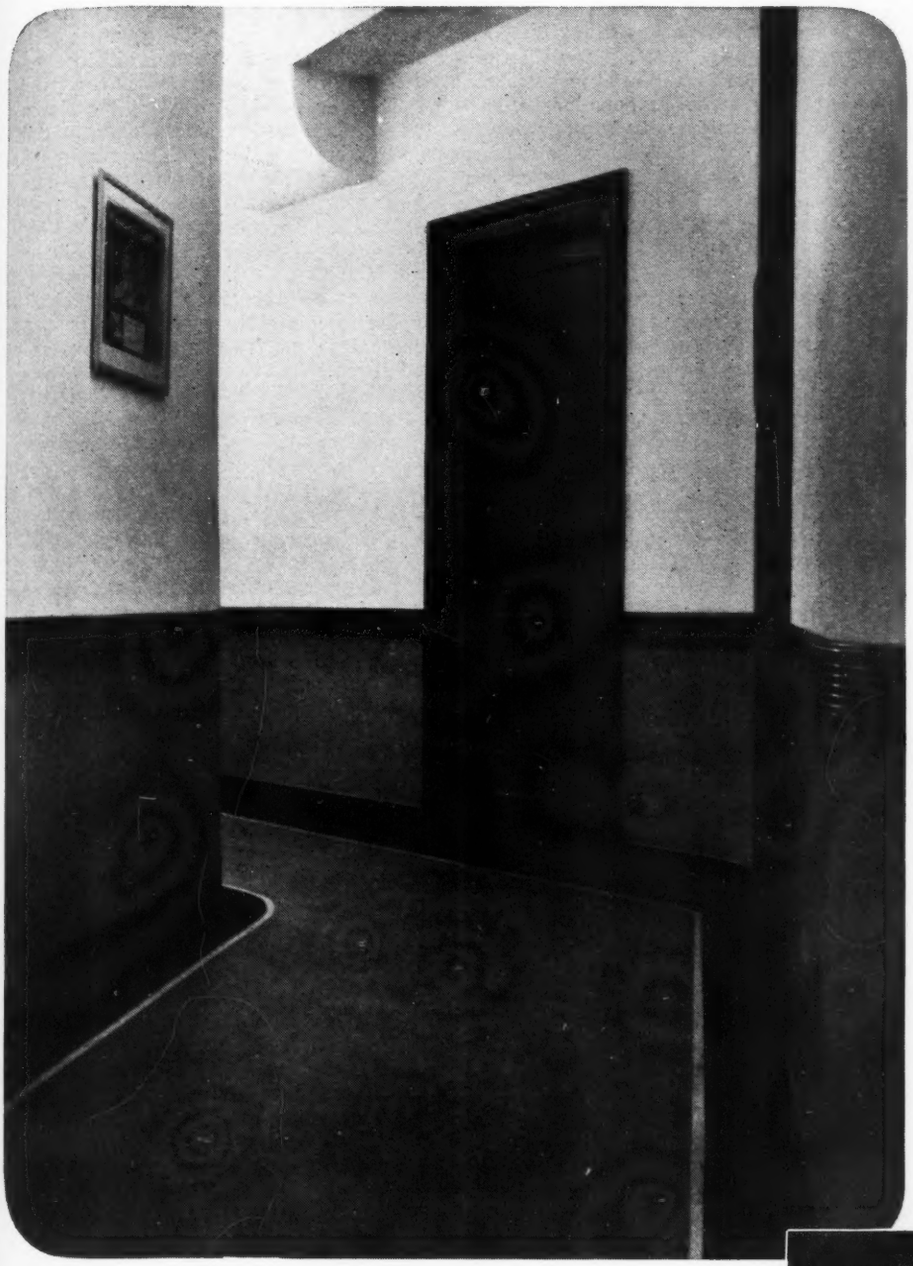

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light upward for other parts of the room. An additional point, which in itself is not directly associated with the amount of light, but rather with the quality of lighting, should not be overlooked. Some form of diffusing material should exist between the lamp bulb and the viewed page of reading matter. This diffusing material softens the light, which means softer shadows and a considerable reduction of annoying reflections from shiny paper. All of these principles are now employed in the study and reading lamps made according to the Illuminating Engineering Society specifications.

Bedside lamps abound in numbers and shapes, yet scarcely any will be found to meet the requirements set forth. They were not designed with these objectives in mind. The I. E. S. study and reading lamp placed on a hospital bedside stand would serve, but its size would probably interfere with the various services that this table must provide. With this in mind, an adaptation of the shade and inner diffusing bowl of white glass could be supplied to be placed on the wall, centered above the bed so as to be out of the way and at the same time more evenly illuminate the page from left to right.

For the general illumination of the room indirect lighting from a central ceiling fixture provides the greatest comfort. At this time an average illumination of five foot candles is recommended. The same general result may be obtained from a fixture mounted on the wall above the patient, projecting light to the ceiling and then throughout the room. This arrangement may possess the advantage of creating the brightest ceiling area slightly back of the recumbent patient's normal field of vision.

Contrasts Are Kept Low

Various arrangements for producing low levels of illumination for night lighting service have been in use. When we come to consider this problem, one of the principal considerations is that of creating a condition in which contrasts within the patient's field of view are kept low and at the same time of avoiding the creation of shadows, particularly grotesque shadows.

Wall pockets near the baseboard or under the bed or other places should be located with care so as to avoid the creation of these shadows. In general, those types of units that restrict their light below the horizontal provide the most satisfactory results. Floors with dull surfaces minimize reflections, which in themselves may produce undesirable effects.

As is often the case, the patient's final convalescent days are partly spent in a comfortable chair. For these days one of the floor lamps made according to I. E. S. specifications will supply the needs of reading as well as the arrangements made while the patient was confined to bed. At the same time its pleasantly illuminated shade will create a pleasant softening glow throughout the room at times when the general lighting is not desired or when the light immediately above the bed for reading is not wanted. Many patients prefer this type of lamp.

Refrigeration Demands—Present and Future

WHAT types of refrigeration do hospitals use? How do they like them? Who buys refrigeration equipment? How much is used in hospitals?

These and similar questions are the basis for a sample study made by The HOSPITAL YEARBOOK. Thirty-eight hospitals in all parts of the country sent in usable data.

Twenty-one of these hospitals have a central brine system, 10 use "multiple" refrigeration, *i.e.* several cabinets served by one compressor without any brine tanks, and 30 have local independent refrigerators. Obviously most of the hospitals use more than one type. This is not true, however, of the smallest institutions reporting. There were 5 under 50 beds, all using local independent refrigerators exclusively, as did 5 of the 7 reporting hospitals of 50 to 99 beds.

Apparently central brine systems and multiple refrigeration are not widely used by hospitals of less than 100 beds.

Opinions varied widely as to the relative value of the three principal types of refrigeration. Thirteen hospitals, rather well distributed as to size, favored the local refrigerators exclusively. They said that local units were less costly to install and repair; easy to move; better in an emergency, since only one box would be tied up; better for use when buildings are scattered, which would necessitate the running of long lines for a central or, perhaps, for a multiple system; give better temperature control; eliminate brine line maintenance and damage to plastered walls caused by leaking lines, and give better access to source of trouble when leaks occur.

One correspondent favored the multiple system as it "gives more comfort and is less expensive."

Some Favor Central System

The central brine system had eight strong proponents, all but one of them in hospitals of 100 beds or larger. This system is simpler, more effective and economical, permits central supervision by a trained engineer, is flexible and reduces the cost of upkeep.

Probably the soundest advice was that given in six replies, namely, that all three systems have uses in large and moderate-sized hospitals. The central brine system apparently is unexcelled for making large quantities of ice and for cooling large units such as food storage coolers, kitchen refrigerators and mortuary boxes.

But for refrigeration on the floors and in various remote places in the hospital there is much in favor of local units. When there are several boxes close to one another, but a considerable distance from the power house, the multiple units seem to have a real place.

Most of the reporting hospitals make ice either in cube trays or in a central brine freezing unit. Several of those who make ice also purchase ice during certain seasons. The hospitals of more than 200 beds were almost unanimous in expressing the opinion that the manufacture of ice in brine tanks was the best system. In the group from 100 to 199 beds, 9 hospitals favor brine tanks and 5 prefer ice cube freezers.

Freezing of ice in bulk ice freezers is done only in hospitals of 100 beds or more, according to this sample. Other institutions use ice cube freezers (of which 129 were reported) or buy ice. One New England hospital cuts its own ice in the winter.

Units for Main Kitchens

The service refrigerators for main kitchens, diet and serving kitchens and dining rooms are by far the most numerous type of refrigerators in all hospitals. The 38 hospitals reported a total of 308 such units. Four hospitals of from 25 to 49 beds had 8 or an average of 2 per hospital. The 7 hospitals of 50 to 99 beds had 19 cabinets or nearly 3 per hospital. In the 15 reporting institutions of 100 to 199 beds, there were 75 service refrigerator cabinets or 5 per institution. Eleven large hospitals (more than 200 beds) had a total of 206 cabinets, or nearly 19 each.

Walk-in and cold storage coolers were the next most numerous group. In terms of average number per hospital they were distributed as follows: the hospitals of from 25 to 49 beds had 1 cooler for each two hospitals; the hospitals of 50 to 99 beds had 1.3 coolers per hospital; for the institutions of 100 to 199 beds there were 3.3 coolers each, and the hospitals with more than 200 beds had just under 5 coolers. *(Cont. on page 88.)*

There were 76 water coolers in these hospitals. The averages for the various groups of hospitals, as given above, were 1½, ½, 3 and 2 water coolers per hospital. Only 4 water coolers for x-ray and other technical purposes were reported.

Refrigerators for laboratory use and for the storage of serums and biologicals were next most frequent, there being 76 in the total group, most of them in the larger institutions. The average number per hospital was 0.75 in the smallest group, 0.71 in the from 50 to 99-bed class, 2.2 in the from 100 to 199-bed group, and 3.2 in the larger institutions. There were also 50 constant temperature cabinets, all but one of them reported by the 11 larger hospitals. Forty-two of these were reported by a 250-bed St. Louis hospital. Twelve refrigerators were reported for other technical uses.

Mortuary refrigeration and waste product refrigeration were reported only by the institutions of 100 beds or more. There were 19 mortuary refrigerators and 8 refrigerating plants for waste products.

Twenty-three of the 38 hospitals reported ice cream freezers or hardening cabinets. Six of the 11 larger hospitals and 10 of the smaller hospitals do not have this useful facility. But all 15 of the hospitals of from 100 to 199 beds are so provided.

Administrator Does the Buying

The purchase of refrigeration equipment is usually the responsibility of the administrator, either with or without advice from other hospital officers. Of 36 hospitals replying to this question, such was the case in 25. In five instances the board of trustees itself carried the responsibility, and in two the chief engineer. An owner, a medical director, a supervisor of charity and the board of health are each responsible in one case.

Several possible improvements in refrigeration equipment were suggested by the hospitals. One institution of middle size, for example, suggested that it would be highly desirable to have separate temperature controls in the three different sections of the food storage cabinet. "When our cabinet is cold enough to preserve meat for any length of time, eggs and vegetables in the next compartment are frozen." This institution also deplored the waste of water used in cooling.

Another institution whose equipment was installed in 1929 complained of the cost of power and circulating water. Several institutions suggested that better insulation should be provided than that which was furnished with their present units. One specifically mentioned the need for a weather strip type of door closing which will not shrink or wear out. Another noted that insulation of separate compartments should be improved.

Here is a novel suggestion one user put forward: "Why not have a machine that could be expanded during the summer and contracted during the winter?" Automatic defrosting, better equipment for manufacture and storage of cracked ice, and a division of present units by installing separate drinking water units were other proposals.

The age of present refrigeration equipment varies widely. One hospital is still using equipment installed in 1910 and two are getting along with 1920 installations. Four hospitals are using equipment installed in the five years from 1921 to 1925 and 13 put in equipment in the second half of that decade. Fourteen hospitals have installed new equipment in the first half of the present decade (1931 to 1935, inclusive) and 4 have made purchases in 1936 or the first few months of 1937.

Of the thirty-eight hospitals, 8 reported that they were contemplating the modernization of their refrigeration equipment, 27 that they were not and 3 failed to reply.

These hospitals also were asked what other plant improvements they had under way or were contemplating during 1937 and 1938. The answers ranged over a wide field including a new wing, 50-bed tuberculosis infirmary and 20-bed preventorium, entire new x-ray equipment, new laundry equipment, new ambulance entrance, anesthesia machines, new laboratory, replacement of dishes and silver (some with stainless steel), new nurses' home, replacement of boilers, modernization of delivery room suite and construction of new nurseries, remodeling and connecting of three buildings on the hospital grounds into a nurses' home for 150 nurses, replacement of kitchen equipment, new $300,000 administration building and receiving ward, and new stoker.

Good Wall Finish Wins

Modern walls are subject to a wide variety of treatment. When fitting that they should assume the warmth and richness of wood paneling, they may do so without benefit of that material at all or without the burden of its cost.

A paneling has been created comprising a mastic treatment over standard and approved fire-resistant and fireproof building boards—4 feet wide, from 6 to 12 feet long and from $\frac{3}{16}$ to ½ inch thick. This surface treatment becomes a part of the board itself, finished in colonial knotty pine, or in mellow-toned oak of the early American and English periods. Moldings of actual wood may be applied to these surfaces, or if greater detail is required to carry out the decorative effect, panels of linen fold design or wide decorative moldings processed in the same manner.

The paneling is easily fitted to any painted or plastered surface — complete dry-out is unnecessary — or it can be erected directly over studs in new construction. The rigidity of the sheet makes unnecessary a smooth ground surface. It is merely nailed on as is wood paneling, and the sheets are light so that one man can easily handle them.

Another interesting feature is that it comes in proper thicknesses so that it can be applied to a wall without disturbing the existing trim. Regardless of the thickness, the surface is always the same so that in remodeling work two or three different thicknesses can be used to accommodate existing conditions.

When the design of the room demands that the wood treatment be carried to the ceiling in the form of beams, the same composition paneling is possible. Pillars can also be completely disguised in the same way. The upkeep is the same as wood; occasional waxing will maintain the finish indefinitely.

Convenient Tourniquet

By Marie X. Long

A tourniquet which may conveniently be made in the hospital has the further advantage of being easy to apply and remove and does not pinch the skin of the patient.

To make, cut a groove in a block of wood about an inch square. Bore a small hole just below the groove and round the corners of the block. Sandpaper and stain, to avoid splinters. Next, fasten a piece of soft rubber tubing, about ¼-inch in diameter, into the block with a wooden peg.

In applying the tourniquet, place the tubing around the extremity, pull it as tight as necessary and slip the loose end into the groove. The contracting rubber holds the tourniquet securely.

Introducing the Nurse

Nurses are more than hands and feet, they are the liaison officers between the bed patient and the outside world. When a nurse first meets her patient she should be properly introduced. If she is accompanied by her supervisor or a doctor she should be introduced by them. If she goes in alone she should introduce herself about as follows: "Mrs. Parker, I am Miss Joslyn, one of the staff nurses on this floor. I'm in charge of this section from seven to eleven each morning and from four to eight each afternoon. I'll be glad to help you in any way I can."

PHYSICIANS . . . HOSPITAL ADMINISTRATORS . . . GRADUATE NURSES . . . DIETITIANS . . . TECHNICIANS

M. BURNEICE LARSON
DIRECTOR

The time has come again to sit and chat with you

The only thing we'd like to talk about is you, and *only* you, if you should feel that we can help you find the job you've yearned to find . . . a thousand times.

We've *many* opportunities while you have few or none to find if all the wishes in your mind and all the turmoil in your thoughts can ever end in a super job you'd love.

You see *we* deal in people; for years our task has been to find the round holes for round Pegs and square holes for square Pegs . . . until we've learned to fit them close as *that*.

Then men and women *with jobs to fill,* with *ideals* in *their* minds, too, they come to tell us they want nurses, physicians, every *kind* of professional help . . . need spirited, eager anxious folks who would come to them with smiles to learn and lick the jobs they'd give.

What could be saner, finer? We find the finest people in the land: spunky, eager folks, smart and kind and lovable . . . and never stop until we find the jobs they'd love, the job they'd lick; square hole, square Peg; round hole, round Peg.

It takes a deal of hunting; takes lifetimes of trying, knowing how; takes an *understanding* that is our greatest pride . . . to find the men and women, to find the jobs, where *each* belongs to the other and never a doubt of that, never a doubt of that.

If you want a job you'd *love* . . . if you've a square job for square Peg, a round one for a round Peg . . . I wonder if you'd think of us, I wonder if you'd write.

The MEDICAL BUREAU

55 E. Washington St.
The top floor of the tower of the Pittsfield Building
CHICAGO, ILLINOIS

HOUSEKEEPING • • • •

Stepping Up the Linen Service

By Mrs. A. B. Tipping

LINEN control is probably the most difficult housekeeping problem in a large general hospital. Particularly is this true when a large proportion of the patients are private ones and must be catered to continually and tactfully. Naturally paying patients resent being limited to any certain number of linen articles.

Climatic conditions in the Deep South, where warm weather extends through three-fourths of the year, also are a major factor. During these warm months it is not unusual to change a patient's linen three or four times daily. Consequently, this increases the problem.

Supplying patients with fresh linen is but one phase of the linen problem. There must be special uniforms for interns, nurses, orderlies, kitchen workers, for practically all employees, in fact. The repair and replacement of damaged articles must be considered as well as the expensive losses incurred because of souvenir hunters.

After many years of experimentation, the system finally adopted by Touro Infirmary, New Orleans, for providing each ward with sufficient linen is simple and practicable. Printed requisitions listing the various articles, such as sheets, pillow slips and gowns, are distributed to the wards. Each morning the respective supervisors write upon them the number of patients in the ward and the number of each article wanted. These requisitions are filled in the linen supply department and delivered to the various wards at 3 o'clock every afternoon. Upon delivery a nurse or attendant checks the linen with the delivery man.

In the event some patients require more than the usual quota, extra supplies are in charge of the ward supervisors and the nurses must apply to them for additional quantities.

The repair of damaged goods and the replacement of worn-out ones must also be considered. Each piece of torn linen is sent from the linen department to the sewing room and there mended if possible. These repaired pieces are then used in the public wards.

Should a piece be damaged beyond suitable repair it is exchanged for a new article, thus maintaining a constant supply level. Missing articles are likewise replenished at these exchange meetings, which are held once a week.

Furnishing and laundering uniforms for employees are expensive items in our budget. However, without control over the attire of these persons there would be an unbearable situation in any well-managed institution.

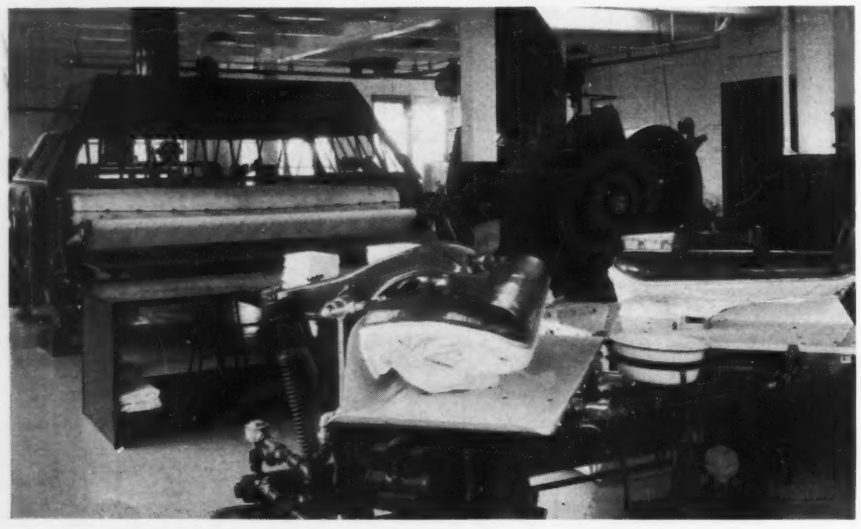
Most employees such as kitchen help and waiters are supplied with clean uniforms daily while orderlies, elevator operators, porters and those doing similar work receive fresh uniforms on alternate days. Sufficient uniforms are delivered to the office of each department head and there exchanged for the soiled apparel.

Colors for these uniforms may vary. Blue-gray coveralls for porters and kitchen help, tan coat and trousers for orderlies and white duck coat and trousers for elevator operators and dietary waiters have been found practicable both for wearability and appearance.

Uniforms of blue and white striped gingham for ward and pantry maids and a light gray cotton suiting with white cuffs for nurse attendants have been found serviceable. Dining room maids' uniforms are aprons of white cotton suiting.

No small item is the problem of outwitting souvenir hunters. Losses caused by these persons necessitate a continual stream of new articles to maintain our supply level. Even the wash cloths disappear by dozens.

The hospital name woven into towels, spreads, tray cloths and the like helps somewhat but not sufficiently. Making the nurses responsible for their individual supplies has not been found practicable and no other system yet tried has proved satisfactory.



Modern machinery enables the housekeeper to speed up the linen service and also maintain a constant supply level in all wards.

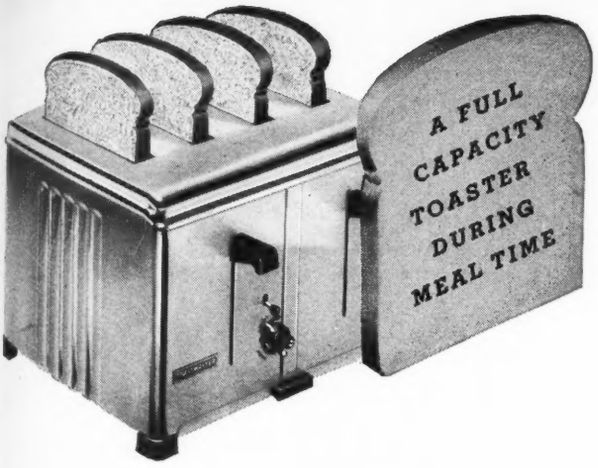
Cleaning Draperies

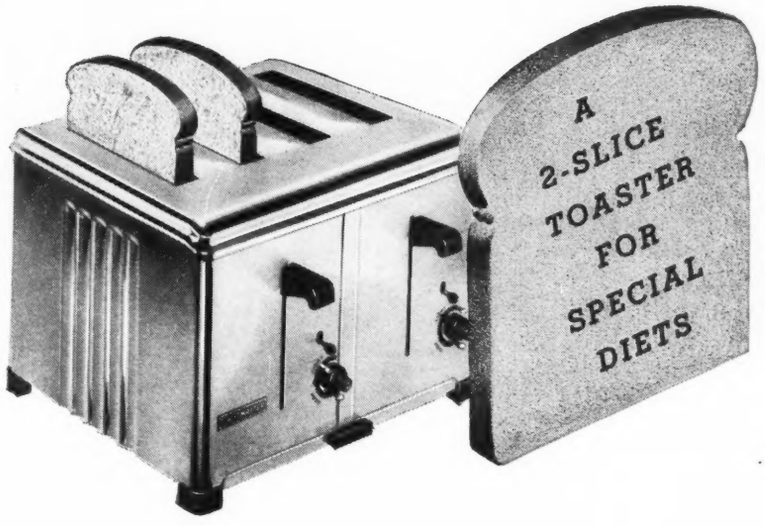
An easy method of removing dust from curtains is the periodic use of the vacuum tools designed for the purpose. If the draperies are very dusty, they should be taken down and placed on a large sheet of cloth or paper on the floor. The special vacuum cleaning brush should be used on both sides.

If the fabric is colorfast and of cotton or linen, the draperies may be washed. But if they are made up of a combination of yarns, they may shrink or be affected by soap. These should be dry cleaned. It is poor economy to select drapery materials that are not colorfast.

For the upholstered couch or chairs, carbon tetrachloride is a highly satisfactory cleansing agent. Spots should be removed just as soon as they occur. An occasional surface bath with this noninflammable cleanser will rejuvenate the fabric and not allow the dirt to become deeply imbedded.

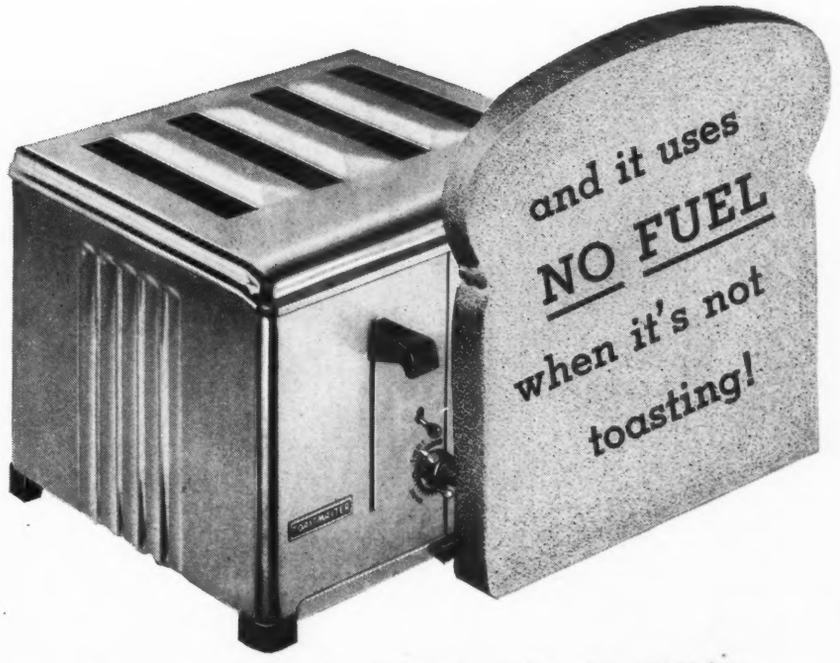
To use this cleanser properly, first remove all top dust with a vacuum tool designed for such a purpose, or brush with a stiff brush. Cover with a cloth or heavy paper the section that does not require cleaning.





YOU pay no bills for wasted fuel when New TOASTMASTER Toaster makes your toast! It uses current only in slots that are actually working . . . it shuts off the instant the toast is crisp and delicious. Every slice costs less—yet every slice is exactly as your patients like it, because the Flexible Timer can never make a mistake! May we send you complete facts?

ONE OF THE FAMOUS TOASTMASTER PRODUCTS
made by
McGRAW ELECTRIC COMPANY
TOASTMASTER PRODUCTS DIVISION
Dept. 12, 231 North Second Street, Minneapolis



Made in 3, 4 and 6 slice sizes and a heavy duty 2 slice unit for diet kitchens . . . small capacity in a construction that will give years of service.

NEW TOASTMASTER *Toaster*

Reg. U. S. Pat. Off.

MAKES MOST OF THE WORLD'S TOAST

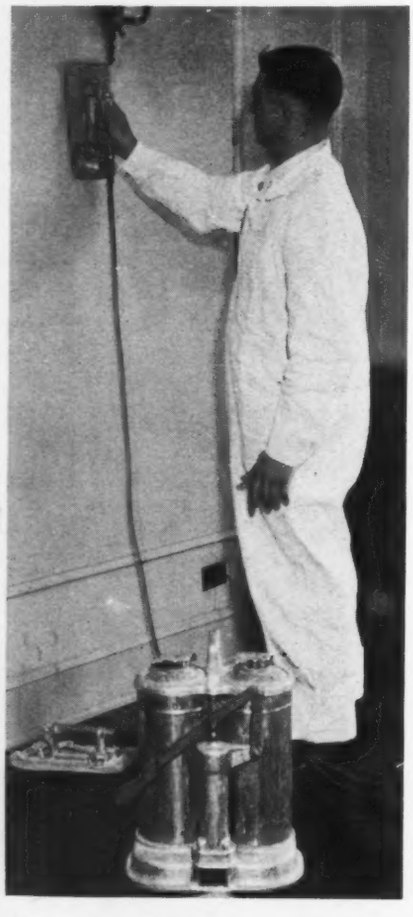
Down With Grime and Soot

By Mrs. Blanche W. Watt

Wall washing by machine at the Evanston Hospital, Evanston, Ill., has reduced working time 50 per cent and made paint and other wall finishes last longer and look fresher.

FOR the last two and one-half years we have been using a wall washing machine at Evanston Hospital, Evanston, Ill., with satisfactory results. All types of walls have been cleaned with the machine. These include corridors, paneling, those papered with washable wall paper and those painted in delicate pastel colors.

The machine consists of two tanks, each holding 6 quarts. One is used for the soap solution and the other for the rinse water. Fastened to each tank is a tube of rubber 35 feet long. A 6 by 12-inch trowel is attached to each tube and a gauge and valve are used to regulate the supply of solutions to the trowel. Covering the trowel is turkish toweling of double thickness, folded and sewed so that no raw edges are visible. These cloths are easily clamped on and are equally easy to remove, so they may be kept clean at all times. The machine is durable, light in weight and easy to move.



With this machine an experienced man can wash from three to five average rooms in an 8-hour day.

When the operator reports for work he brings everything needed for the day, including from thirty to thirty-five trowel covers. This is our daily average. Before mixing the soap solution the condition of the wall is noted to determine the strength of the solution necessary. For surfaces washed once a month to once every six months, we use 1½ to 2 ounces of any good neutral soap to 1 gallon of water.

Before beginning work both tanks are filled, 40 pounds of air pumped into each tank, the trowels attached and the gauges and valves adjusted. Less than fifteen minutes is needed for preparation. In order to keep a sufficient amount of pressure to force the solutions through the tanks to the trowels, air is pumped into the tanks three or four times during the day. Solutions in both tanks are checked frequently to make sure they are clean.

Inexpensive trowel cloths are purchased in dozen lots. They stand up well under service and are sent to our laundry daily. As compared with wall washing sponges we find that turkish toweling costs less, lasts longer and is easily kept clean.

Machine Is Easy to Operate

The knack of handling the equipment may be quickly learned by the intelligent worker. We were fortunate, however, in having among our employees a man who had previously had demonstration experience with the machine. This experienced and competent workman can cover from three to five rooms, 12 by 16 feet, with one or two windows in eight hours. In our opinion the ordinarily capable worker could gain enough experience in a few weeks to approximate this speed. With our trained man there is no streaking or lap marking and no drop cloths are needed in corridors and public rooms. Undoubtedly, a less experienced man would be unable to do the work so neatly at first, but this skill can be acquired.

We have found that this method of washing does not wear the paint surface as much as does ordinary washing by hand, and it has reduced our schedule of repainting at least one-half.

The only hand washing we find necessary to do is where the flat, straight-edged trowel interferes with convex or curved corners or where there are many pipes and obstructions in walls and ceilings. This type of trowel would likewise not be practical on highly stippled walls.

Machine wall washing has reduced our time of actual labor fully 50 per cent. The amount of soap used is somewhat less than 10 per cent of that formerly required. In addition to a marked saving in time, labor and materials is the satisfaction of clean walls with less frequent repainting.

Accuracy in Laundry Count

By Marie Neher

An unusually accurate laundry count has been developed for the University of Chicago clinics and affiliated hospitals. All laundry is checked through the housekeeper's department. Ordinary soiled linen is sent directly to the soiled linen room. Operating room linen and linen from the division that might carry infection are sent down in bags, that which is merely mussed being kept separate from the soiled.

The bags are put in a huge sterilizer adjoining the sorting room, and after being sterilized that which was merely mussed is returned to its department. The soiled is sorted, counted and listed along with the other soiled linen.

Two lists of all laundry sent out are made, one to go to the laundry the other to be kept in the central linen room.

Clean linen is returned by the commercial laundries in bundles—sheets and spreads in packages of ten, towels and pillow cases in lots of fifty, pajama coats and trousers in bundles of twenty-five. The items are counted and sorted and the lists are checked off. Daily department requisitions are filled and the remaining laundry placed on the shelf, that requiring mending being first sent to the sewing room.

A monthly check-up on discrepancies is made with the representatives of the laundries. The daily average of work amounts to eight trucks of 217 pounds each, and the number of items is over 200. In one month, out of 4,435 pillow cases of a certain kind, there was a shortage of three; of 4,300 drawsheets, a shortage of two, of 526 tray covers, a shortage of one.

THE HOUSEKEEPER'S CORNER

• Mrs. Effie Armitage is the new housekeeper at Grant Hospital, Chicago. Previously Mrs. Armitage had been housekeeper and supervisor of the nurses' home at St. Luke's Hospital, Chicago, and before that housekeeper and matron of the nurses' home at the Children's Memorial Hospital, Chicago.

• Mrs. Alice Gallup, housekeeper at Highland Park Hospital, Chicago, was welcomed as a new member of the Chicago chapter of the National Executive Housekeepers Association at its November meeting. Chapter members exchanged ideas on methods of scheduling personnel on a six-day basis and Mrs. Marion Wyatt, housekeeper at the Sherman Hotel, read a paper on "Housekeeping in England." The group will give its Christmas party December 16 at the Stevens Hotel.

• A room for old, badly worn and torn linen is an innovation that has proved to be a convenient timesaver at Presbyterian Hospital, Chicago. The plan, as worked out by Bernice Stein, housekeeper, is to have all pieces not in good condition sent directly to the room after laundering. They are then sorted by the girl in charge. Pieces that can be mended are laid aside, sent to the mending woman and put in service again. Those that can no longer be used are torn into convenient sizes and packed in bundles of a dozen or more of the same size. The bundles are distributed to the various floors for cleaning and dusting.

• Old draperies that are worn in spots but still contain good material may be given a new lease on life by cutting the usable parts into strips 6 or 8 inches or wider. The strips are then sewed together, using a narrow upholster's fringe at each seam or a contrasting piping. The vertical lines make the drapes effective and permit introduction of a new color note.

• Diapers for the nursery at Henrotin Hospital, Chicago, are folded in pairs to the size required in the laundry before being sent to the sterilizer. This saves the nurses in that department an hour or more each day. In return, the nursery helpers sort the linens before they are sent to the laundry.

• After use, rubber gloves in a large hospital in the Middle West are sent to the washing room. Sorting the gloves for size, for tears or for other repairs follows the careful washing. The gloves are then placed in bags where they remain until they are powdered and sent to the sterilizer. Those needing repairs are collected in lots of several dozens and all are repaired at the same time.

• Paint is a more satisfactory finish for radiators than gilding with silver or gold paint, which are poor heat conductors. Use paint matching the wall in color to make unscreened radiators less conspicuous.

• A mimeographed slip is given maids at Presbyterian Hospital, Chicago, who are to clean and check out rooms. The accompanying illustration shows how articles are listed; blank spaces are left for checking items needing attention. When the repair or cleaning has been completed that item is marked "OK." These slips save much time for the housemen, painters and window washers and enable the housekeeper to see at a glance what work has been done in each room.

• A remedy for squeaky wooden floors is to tack down the offending boards with nails that have been covered with some preparation that will give better tractive surface than that of the ordinary nail. A Philadelphia office building manager makes his own. He simply immerses nails in shellac, pours off the liquid and lets the nails dry. Although the amount of shellac used is small it holds the nails securely.

• The new executive housekeeper at Mountainside Hospital, Montclair, N. J., is Mildred Burt, a graduate of Northeastern University, Boston.

• A system for cleaning small rugs in the private rooms at Presbyterian Hospital, Chicago, provides for having them swept with a carpet sweeper each day and given a careful vacuum cleaning once a week. At frequent intervals the rugs are washed in a special rug washing machine.

• A trick for storing mattresses is to pile them one upon the other and place long, thin, 6-inch boards between each of them. These strips of wood help to keep the mattresses from becoming bumpy, provide some ventilation and assist in preventing mildew, says Jane Van Ness, executive housekeeper, writing in *Hotel Monthly.*

HOUSEKEEPING FORM IN USE AT PRESBYTERIAN HOSPITAL, CHICAGO

Room No. 435 *Date 9-30-37*

	Repair	*Oiling*	*Paint*	*Clean*	*Soiled*	*Changed*	*Washed*	
Furniture Bed								
Chairs								
Dresser								
Tables								
Screen								
Waste basket								
Ash trays								
Lamps								
Wash stands								
Footstool								
Rugs								
Windows								
Drapes, curtains								
Window shades								
Venetian blinds								
Mirrors, glasstops								
Lamps, lamp shades								
Bathroom Fixtures								
Rugs								
Faucets								
Commode								
Utensil chest								
Miscellaneous								

• Elizabeth Gunn has been appointed housekeeper at the United Hospital, Port Chester, N. Y.

• New departures in hotel decoration frequently are adaptable to use in hospital rooms, in lobbies and in hallways. Hospitals are following hotels in many practices, and there is evidence that the trend toward dark ceilings is creeping into hospitals. Supt. Hilda Whitefoot of Lutheran Deaconess Hospital, Beaver Dam, Wis., has done some experimenting in this direction in a hospital addition of twenty-six beds.

Two hotels that are adopting the use of dark ceilings in interior decoration are the Stevens and Sherman in Chicago. The Stevens is using a dark green ceiling with lighter green walls or a dark rose ceiling with light rose walls. Another variation is light ceiling and three light walls; the fourth wall is dark—maroon, for example—and the bed is set against this wall, so as to reduce the prominence of the bed in a room that serves for general daytime use. In the last type of decoration a maroon bedspread is employed. At the Sherman Hotel some 300 guest rooms have been redecorated with brown ceiling, two brown walls and a green carpet, or with blue ceiling, two blue walls and a gray carpet.

CANNED FOODS IN THE CONTROL OF LATENT AVITAMINOSIS A

● Cases of severe vitamin A deficiency are extremely rare in this country. Recent medical research, however, has shown that latent avitaminosis A occurs more frequently than hitherto might have been suspected (1).

Fortunately, latent avitaminosis is capable of early clinical detection. One of the first effects of prolonged suboptimal vitamin A intake is a lowered dark adaptation of the eye. Any deviation from normal in this respect can be readily determined by the photometer. A second direct result of continued mild avitaminosis A is the cornification of epithelial cells in certain tissues. The presence of such cornified cells in scrapings from the bulbar conjunctiva is indicative of avitaminosis A.

Using such methods, investigation has been made to determine the frequency of latent avitaminosis A in representative groups of American adults and children. The results of these researches are of interest to everyone concerned with human nutrition.

First, it has been shown that the incidence of latent avitaminosis A in America is surprisingly high. For example, in one instance (1d) more than one-third of the adult group under investigation displayed evidences of mild vitamin A deficiency; again, from one-fourth to three-fourths of the members of representative groups of children displayed similar manifestations (1b).

Second, it has been found that, in general, subjects exhibiting symptoms of mild avitaminosis A had been maintained on diets which may be considered suboptimal with respect to vitamin A. Last, but by no means least, it appears that these avitaminoses may be corrected and controlled by specific vitamin A therapy; by readjustment of the diet to provide a more liberal supply of vitamin A; or by a combination of these two procedures.

When readjustment of the diet to increase the vitamin A intake is being considered, attention might well be directed to commercially canned foods. Biochemical research has established that the canned varieties of foods notable for their vitamin A content are valuable dietary sources of the vitamin (2).

Available at all seasons on practically every American market, commercially canned foods will prove economical and reliable in the formulation of dietary regimes calculated to control latent avitaminosis A.

AMERICAN CAN COMPANY

230 Park Avenue, New York City

1a. 1934. J. Amer. Med. Assn. 102, 892.
b. 1936. Ibid. 106, 996.
c. 1937. Ibid. 108, 7 and 15
d. 1937. Ibid. 109, 756.
2. 1931. J. Nutrition 4, 267
1932. Ind. Eng. Chem. 24, 650.
1933. J. Amer. Diet. Assn. 9, 295.
1935. Amer. J. Public Health 25, 1340.

This is the thirty-first in a series of monthly articles, which will summarize, for your convenience, the conclusions about canned foods which authorities in nutritional research have reached. We want to make this series valuable to you, and so we ask your help. Will you tell us on a post card addressed to the American Can Company, New York, N. Y., what phases of canned foods knowledge are of greatest interest to you? Your suggestions will determine the subject matter of future articles.

The Seal of Acceptance denotes that the statements in this advertisement are acceptable to the Council on Foods of the American Medical Association.

FOOD SERVICE • • • • •

Conducted by Anna E. Boller, Rush Medical College

Yuletide Customs and Novelties

By Anna E. Boller

WITH the frost on the ground, the branches bare overhead and a faint hint of snow in the gray skies, we know that winter is well on the way, and that someone is bound to say, "My goodness, before we know it, it will be Christmas!"

In making our plans and preparations, we seldom stop to think why certain things are out of all the year sacred to this season. Santa Claus, the Christmas tree, decorations of holly and mistletoe and the exchange of gifts are taken as a matter of course.

The origin of Santa Claus is a controversial subject. Many lands have claimed the saint as their exclusive property. The idea seems to have originated in St. Nicholas, a wealthy and kindly man living in Lycia, Asia Minor, years and years ago. He became the Bishop of Myra but everyone called him St. Nicholas. While he was generous and loved to bestow gifts upon the poor, it embarrassed him to be thanked for his largesse. Therefore, he made a habit of doing kind deeds under cover of darkness, leaving with this family or that a well-filled purse but giving no indication of the giver's identity. Stories of the saint's generosity and kindness were told through the years and were passed on from parents to children, probably being exaggerated in the telling as such stories generally are. Possibly a visit from St. Nicholas was held out as a reward for being good.

The custom of gift-bearing was prevalent in England as far back as the tenth century, when on St. Nicholas Day a boy bishop was elected, who paraded through the streets distributing gifts to the poor. This ceremony continued in England, Scotland and France throughout the Middle Ages, but finally the natural rivalry and revelry of boys turned the day into a farce, and the boy bishopric was abolished by an act of Parliament. However, the spirit of St. Nicholas continued to wend its way down the ages. He became known as the children's patron saint, and as St. Nicholas Day fell in December, gradually the celebration of his day merged with the Christmas celebration. Good children found on Christmas morning that St. Nicholas had made a visit during the night, leaving candy and toys.

In Germany he was known as Kriss Kringle, in France as Pere Noël, the Russians called him by his own name, but in Holland, it was changed to Santa Claus. The last name was brought over to this country, together with the Dutchmen's conception of the man as a fat, jolly, old "elf" in a red suit, long white beard, and with reindeer to pull his sleigh.

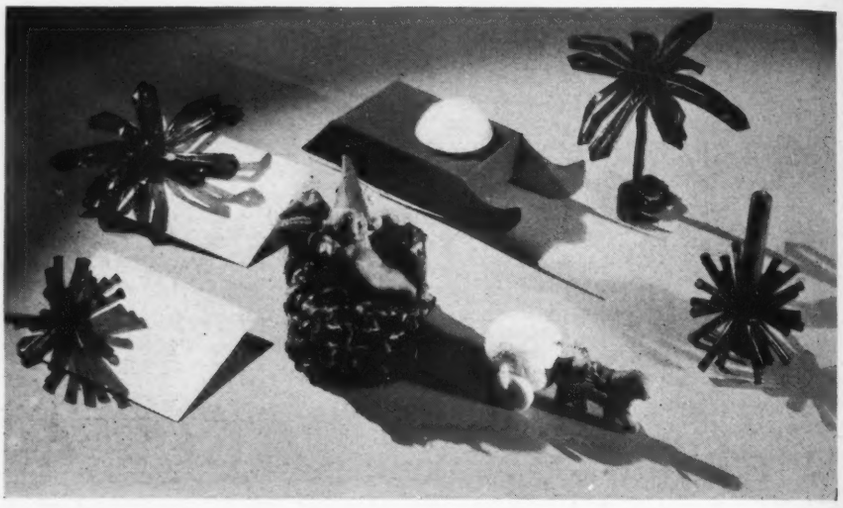
Why do we look for holly and mistletoe when planning our Christmas decorations? These were once considered emblems of hope and peace and were most appropriate for decorations on the day of days.

The use of candles and open hearths as Christmas symbols probably goes back to our early ancestors, the sun worshippers, who celebrated at this time of year because the sun, which had been growing steadily weaker, seemed to have reached a turning point and from then on became stronger and brighter again day by day. They had a fear that the sun might some day disappear entirely, and kept their fires burning constantly in case of such a catastrophe.

The Christmas tree is another symbol, the beginning of which is lost in antiquity. The early Romans decorated their homes with evergreen at this season of the year, probably because there were no other green plants. In Munich, the tree itself was first used in home, church, cemetery. In the last named spot it was supposed to bring cheer to the departed souls.

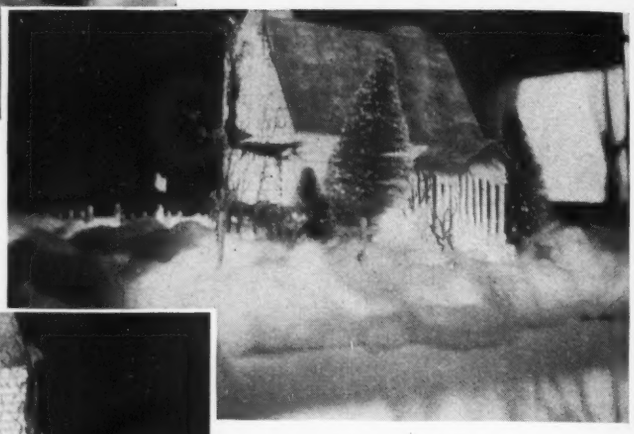
As well as being a time of giving, Christmas has always been a time of feasting, so much so, in fact, that at one time the church found it necessary to frown upon the more frivolous celebrations and to direct parishioners to pay more attention to the religious aspects of the season. Possibly the clergy had good reason for displeasure, and one can hardly blame them when one reads of an early French custom that was very popular. The parishioners brought pies, cakes, wine and other delicacies to the church, and these were placed on a table in a corner. The food was called "de fructa," and when, at vespers, the verse "de fructa ventris tui ponam sedem tuam" was reached, it was the signal for a united stampede on the refreshments, and with much laughing, pushing and shouting, the entire congregation carried off whatever they could lay their hands on.

Christmas food customs vary considerably according to racial and national customs. The one article of food that has been carried forward from the earliest days and has been popular in one form or another in many lands is mince pie. A recipe dating back to 1394 gives as the ingredients a pheasant, hare, capon, two partridges, two pigeons and two rabbits, all boned and put into a paste in the shape of a bird, covered with livers, hearts and seasonings of spice, catsup, pickled mushrooms and gravy made from the combined bones. In 1596 mince pies were known in England as "mutton pies," and later neats' tongues were substituted for the mutton. In early New England mince pies



Homemade favors for the patients' trays express the true Christmas spirit.

For favors mentioned but not described see The MODERN HOSPITAL, December, 1931, and December, 1934.



In the best holiday tradition are these centerpieces liberally sprinkled with silver snow. Clever fingers may fashion the house and the trees may be bought for a few cents and placed in drifts of white cotton.

White mints cut to look like stones and held together with frosting are used for the church below. The fence is of candy.

consisted of "neats' tongues, chicken, eggs, raisins, orange and lemon peel, sugar and various spices," which is an approach to the mince pie we know today.

Many songs and poems have been written about the Christmas pie, and among the peasants of Shropshire there existed a superstition that "a person will enjoy a happy month during the next twelve, for every mince pie he eats at a neighbor's house during the twelve nights between Christmas and Epiphany." Every good housewife, therefore, was well supplied with mince pies to offer her visitors.

The records of some of the ancient Christmas banquets are enough to make the dietitian shudder. Our forefathers must have indeed been hardy to have survived course after course of rich and heavy food and to have lived to celebrate another Christmas. One Christmas dinner, as listed in a cook book of 1671 has only two courses, but there are eleven dishes in the first course and twenty in the second. As late as Christmas, 1880, Delmonico's served as the meat course loin of beef, turkey, Baltimore terrapin, saddle of venison and partridge, all of which were supposed to be eaten.

This may seem a far cry from the Christmas of today and the plans for the hospital celebration, but it may give the busy dietitian a moment's chuckle, and it is interesting to know how customs originated and have been passed on from generation to generation, being modernized according to the advance of civilization but still bearing traces of their early manifestations.

Many dietitians have found it a happy custom to spread the Christmas celebration over as long a period as possible. The patient in the hospital, if he is well enough to be thinking about it, is usually feeling depressed. Even though he may make a determined effort to be cheerful, thoughts will drift to the home group and what he would be doing if he could.

Some dietitians have found that everyone likes to be "in on the preparations." Nurses, student nurses, student dietitians and medical students can usually be pressed into service without much urging in the making of favors and menu greeting cards. Often the convalescent patients, with time hanging heavy on their hands, are glad to join in on some of the less arduous work, like filling stockings for the children's ward.

Christmas is a time of giving, and while the ready-made novelties are beautiful and clever those which have been made in the hospital, into which someone's time and thought have gone, are more highly prized because they express the true spirit of the season.

It is well to assemble your materials in plenty of time. Lay in a stock of red and green crêpe paper, red and green cellophane sippers and any other odds and ends that might be used. Greeting cards, nut cups and tray favors can be made up well ahead of time. Often there is someone in the hospital with a special genius for planning new and original favors or tray decorations.

Always, there is someone who can be coaxed into a Santa Claus suit to surprise and delight the small patients in the children's ward.

It is a good idea to start your celebration on Christmas Eve, with a lighted candle on the supper tray. The popular little favor, made by pressing a tiny birthday candle into a marshmallow or large gumdrop and tieing a life-saver to the side with bright ribbon for a handle, can be used over and over again. Another effective candle-holder is made by cutting red cellophane sippers in lengths of about 2 inches, dipping both ends in green sealing wax, and fastening them in the middle around the base of a 3-inch candle. Both ends of the sippers are then bent outward.

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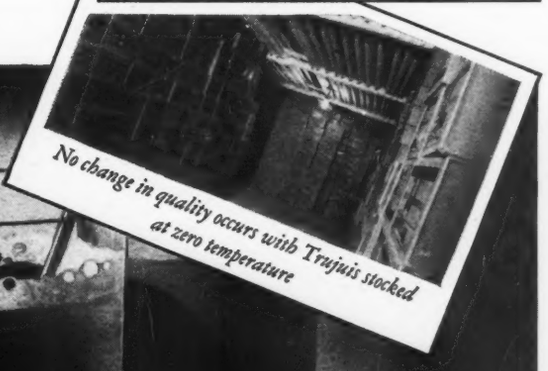

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Your Guests Enjoy Trujuis

On the breakfast tray, a greeting card or combination menu and greeting card may be used. Orange Memorial Hospital, Orange, N. J., presents its menu in an attractive folder, made by pasting pictures cut from old Christmas cards and pasted on brown wrapping paper. A mimeographed menu slip is fastened inside with a red cocktail pick. Or the menu may be written on the inside with red or green ink.

Mount Sinai Hospital, New York City, recently distributed souvenir menus, with the actual Christmas menu printed on one side of the page, and facing it the following:

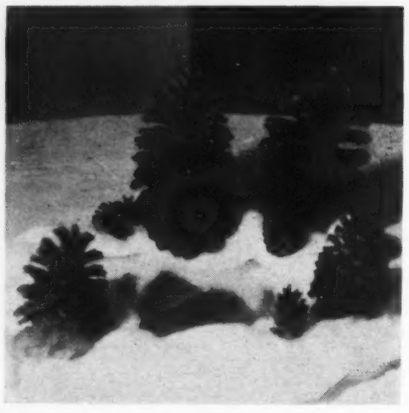
YE CHRISTMAS MENU
Grace
Conscience, Clear
Kindness Good Cheer
Tender Memories
Charity, Served With Discretion
Peace Love Truth
Long Life, Stuffed With Usefulness
Hearts of Courage
A Large Portion
Affection Happiness
Sweet Thoughts
Best Wishes for Early Recovery
MIZPAH

Sprigs of holly, mistletoe or evergreen tied with bright red ribbon will brighten up the trays throughout the day at little cost. Again the red cellophane sippers may form the basis of effective tray decorations. A poinsettia is easily made. For each petal, flatten a sipper, place a wire through it, and fold, bringing the ends together, and making a point at the fold. The petals may be wired together making an attractive flower. A sipper or a heavy wire should be covered with sealing wax or green crêpe paper for the stem, and the leaves may be made of green sippers in the same way as the flower petals were made. Clusters of the red sippers tipped with green or white sealing wax may be glued to a card on which a Christmas greeting or menu is to be written.

A jolly figure brightens this tray.

At dinner time the nut cups appear. Here again sippers may be used in a variety of ways. An unusual one is the Santa Claus sleigh pictured here. It is one of the easiest to make. The pattern will be supplied on request.

After-dinner favors made of nuts and fruit are always popular, and amusing little animals and figures may be made with the aid of toothpicks and ribbons. An apple Santa Claus may be put together in different ways, combining raisins, nuts and marshmallows. A candy cart, drawn by an animal cracker, will be hailed with delight by the children. A large gumdrop or marshmallow is used for the cart body. On each side white life-savers are placed for wheels, securely fastened with a pipe cleaner. The "animal" is placed between toothpick shafts, and tied to them with a bit of ribbon, and the cart is ready to go to the party!



Pine cones in snow are decorative.

Children will love a Santa Claus cake, and it also has holiday appeal to adults. The chimney is made by frosting a square of cake with icing, colored bright red with vegetable coloring. Stripes of white icing are put on with a fine pastry tube or toothpick, to represent the mortar between the bricks. Santa Claus is made of a peanut, pressed into the top of the cake, as though he were going down the chimney. A wisp of cotton forms his hair, another his flowing beard; his eyes, nose and mouth are drawn on with ink or crayon, and a twist of red crêpe paper forms his sack and another his cap.

Suppertime is a good time to get in the decorative salad. Usually the dinner has been a fairly heavy one, and a dainty fruit or fruit and gelatin salad may be the mainstay of this meal. There are many ways of making this attractive. With the aid of pimiento petals and green pepper dots a poinsettia can be arranged in the bottom of the gelatin mold. Snowballs or snowmen can be made of cheese.

In planning the Christmas dinner menu, dietitians all over the United States are working out well-balanced Christmas dinners, bearing in mind that while a Christmas dinner is a rather set menu consisting of turkey, dressing and plum pudding, it must contain a few of the out-of-the-ordinary foods, and even more important it must be suited to the patients' needs, as well as their personal tastes.

The following menus have been served in hospitals in previous years. Of course, these are modified for patients on special diets, but it will be found that they contain all the ingredients of the well-planned normal diet:

I

Cranberry cocktail
Roast turkey Giblet gravy
Cornbread dressing
Escalloped cauliflower
Buttered lima beans
Hot biscuits
Celery Olives
Plum pudding Hard sauce

II

Roast turkey
Dressing Gravy
Mashed potatoes
Candied sweet potatoes
Buttered string beans
Orange basket salad
Greengage ice cream
Candy Nuts

III

Tomato juice cocktail
Roast turkey Walnut dressing
Mashed potatoes Giblet gravy
Cauliflower, paprika-butter sauce
Celery curls Spiced pickles
Raw cranberry and orange relish
Hot rolls Strawberry jam
Butterbrickle ice cream
Cherry cake
Nuts Mints Raisin clusters

A buffet supper for the nurses and staff is an excellent solution for the final meal of the day. It makes it possible for many of the maids to have their half-day off, and the nurses will welcome the informality of serving themselves. The nurses' dining room has, of course, been decorated for the day, and one of the attractive centerpieces here shown can be used on the large main table. These centerpieces may be as elaborate as time permits.

A candy church was used last year at Grandview Hospital, La Crosse, Wis. It represented a good deal of time and thought on the part of someone who liked to do that sort of thing. The building was made of white mints, chipped to resemble stones, and cemented together with powdered sugar frosting. The fence around it was made of candy cigarettes and a candy gravel walk led to a rock candy fountain. The walk around the church was made of candy-coated gum lozenges; the roof, of red and gray gum.

A simple arrangement of pine cones, sprinkled with artificial snow or a sugar solution that looks like snow when it dries, gives the appearance of tiny snow-covered Christmas trees and is an effective centerpiece.

Dainty salads, platters of cold meat, rolls and fruit cake will be most satisfying, with nuts and fruits to nibble on while talking over the events of "another Christmas."

In both acidosis and alkalosis, Karo is a carbohydrate of choice in the emergency of treatment . . .

CAUSES OF ACIDOSIS		CAUSES OF ALKALOSIS	
EXCESSIVE ACID FORMATION		**EXCESSIVE LOSS OF ACIDS**	
Acid	*Disturbance*		Hyperventilation
Aceto-acetic B-hydroxybutyric	Starvation Cyclic vomiting Diabetes Ketogenic diet		Tetany
		CO_2	Cerebral lesions (respiratory center) Hysteria Excessive crying
Lactic	Asphyxia Intestinal intoxication Respiratory failure Shock Burns	HCl	Vomiting Pyloric stenosis Intestinal obstruction
DEFECTIVE ELIMINATION		**EXCESSIVE INTAKE OF ALKALI**	
Metabolite	*Disease*	$NaHCO_3$	in Pyelitis in Nephritis
Phosphate	Nephritis		
Carbonic acid	Emphysema Respiratory obstruction Myocardial failure Narcosis		

From Kugelmass' "Clinical Nutrition in Infancy and Childhood"—(Lippincott)

TREATMENT of acidosis is designed primarily to correct the underlying cause. **In most types, fluids and fruit juices with Karo are forced every hour.** In cases associated with ketosis (except where it is a disturbance in carbohydrate metabolism, as in diabetes mellitus) 20% dextrose is given intravenously at repeated intervals. In case of diabetes, insulin is given, by some authorities, simultaneously one unit for each gram of dextrose, until the condition is controlled.

TREATMENT of alkalosis depends upon the cause. The most common variety in children is that resulting from prolonged vomiting with loss of acid, salt and body water. **No food is given by mouth except fluids with Karo,** and saline injected intravenously. If alkalosis is the result of alkali administration in the presence of nephritis with poor kidney excretion of salts, **large amounts of fluids with Karo will favor excess base elimination.** Alkalosis from excess alkali administration is alleviated by **forcing fluids with Karo.**

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★ **Infant feeding practice is primarily the concern of the physician, therefore, Karo for infant feeding is advertised to the Medical Profession exclusively.**

Favors for Christmas Tray

By Bertha B. Ashley

ARE your plans made for the little favors that mean so much on the patients' trays at holiday time? Are you going to help your fellow-workers, who cannot get home, have a Merry Christmas this year?

Where will you get your idea? It is not necessary to be clever or original yourself. Store displays, if you are in the city, suggest many things. Magazines have a wealth of material or you are indeed fortunate if you can just go to the woods and draw upon Dame Nature's supplies.

I like to have everyone in my department, from the chef to the dishwasher, share in the plans for the holiday and so become enthusiastic and inspired by the Christmas spirit.

Lighted trees and garlands of holly make the hospital festive.

Early in the month we begin talking about what we will do and many a useful suggestion is offered by a maid or porter. It is surprising how much talent is to be found right in your own kitchen.

Sometimes it is necessary to call upon the services of the carpenter and painter or upon the electrician. The more people who become interested in your plans the more enthusiasm there will be and the easier the work will be handled.

For the breakfast tray on Christmas morning we like a small white card having in one corner a drop of green sealing wax to hold up a small red candle. The candle may be lighted as it goes into the patient's room. The card may be decorated as elaborately as you wish with holly made of green and red wax or simply "Merry Christmas" printed diagonally across the card in green ink.

A miniature holly wreath holding the patient's name card makes an attractive favor. A circle of wire is bound with tin foil and the holly berries may be made of small pea beans covered with red cellophane. A twist of the paper is left long enough to twine with the wire circle and to be covered with the tin foil. The leaves may be made of green cellophane over gumdrops, or artificial leaves may be purchased. A red bow at one side adds the finishing touch.

A small piece of homemade fruit cake done up in cellophane and tied with a ribbon gives a festive touch to dinner. Canapés made of tomato jelly cut in various shapes and garnished with parsley and mayonnaise served on doilies or on lettuce make a different first course.

Poinsettia salad is nothing new but try it with pineapple ring as a foundation and strips of red cherry radiating from the center, with Angelica or green pepper stem and leaves.

International Salad

At a meeting of the Stewards' Club last spring, Marco Yerkovich, chef de cuisine of International House, Chicago, demonstrated an International Salad. He has kindly contributed the recipe for this delicious salad to dietition readers of The MODERN HOSPITAL.

Ingredients	*Amounts*
Julienne of chicory	1 ounce
Julienne of celery cabbage	1 ounce
Julienne of raw, fresh, crisp spinach	1 ounce
Bean sprouts, blanched and cooled in ice water	2 ounces
Julienne of bamboo shoots	1 ounce
Julienne of roast ham	1 ounce
Julienne of cooked chicken, light and dark meat	1 ounce
Ripe tomatoes, cut in eight wedges each	2
Pure olive oil	1 gill
Lemon juice	1 lemon
Salt	To taste
Fresh ground black pepper	To taste
Garlic clove	To taste
Sesame seed, toasted	
Mayonnaise	
Green leaves of lettuce	

Use a large bowl or dish pan for the mixing bowl; be certain that it is large enough so the ingredients will not be crushed. First rub the bowl with the garlic, leaving no pieces of garlic in the bowl, just the essence of the garlic clove. Put all ingredients, except the sesame seed, mayonnaise and lettuce in the bowl, and mix thoroughly but lightly. Place a leaf of lettuce on a plate, and put a mound of salad mixture in a pyramid shape on the lettuce. Top with well-beaten, fluffy mayonnaise and sprinkle toasted sesame seed on top of the mayonnaise.

For a small dinner salad serve about 2 ounces for each serving; for a hearty serving, use about 6 ounces.

Snacks Mount to 26,501 Meals

Snacks are simple little things, served between meals—glasses of milk, eggnogs, ovaltine, chocolate, cocoa, tea and toast, fruit juices, tomato juice —but at the end of a year the Municipal Hospitals of the City of Winnipeg discovered that they had served a total of 79,502 of these snacks, an average of 6,625 each month. On the theory that three snacks equal a meal, the hospitals discovered that they served 26,501 meals, apart from the 288,220 regular meals, a total of 314,721 meals. As proof that three snacks do equal a meal is offered the cost of raw foods. A meal, when snacks were not included in the average costs, was $0.0893. The average cost of a meal, when three snacks were included as a meal, was $0.0813.

Christmas Tray

Cream pea soup, roast chicken or turkey with dressing, fried potato balls, Christmas wreath (spinach and shoe-string beets), fresh fruit salad with whipped cream and nuts, bread and butter, pear royale (canned pears, vanilla ice cream, raspberry sauce) and coffee. *Prepared by Mary Edna Golder, dietitian, St. Anne's Hospital, Chicago.*

Rolled Breast of Lamb

Breast of lamb	2 tablespoons lard
¾ pound bulk sausage	Salt and pepper

Have bones removed from breast of lamb. Spread it with pork sausage, roll as a jelly roll, and and tie or skewer into shape. Brown on all sides in hot lard. Add ½ cup water, cover tightly and let cook slowly either on top of stove or in the oven until done, about two hours.

FOOD FOR THOUGHT

• Dr. R. P. Williams of the Bell Telephone laboratories and Dr. J. K. Kline of the research laboratory of Merck Company have collaborated in a research which has led to an artificial development by chemical methods of Vitamin B_1. Part of the work was carried on at Columbia University in collaboration with several other scientists. It is claimed that the vitamin can be produced much more simply by the synthetic processes than by previously developed methods of extracting it from natural sources.

• A novel way of making hamburger or meat patties uniform has been worked out by Mary Edna Golder, dietitian at St. Anne's Hospital, Chicago. She has had a well-finished white pine board, 2 feet by 8 inches and ½ inch thick, prepared with three large holes, 3½ inches in diameter. The meat may be pressed compactly into these holes before cooking. This makes them uniform in size and convenient for placing in split hamburger rolls.

• Beriberi, a serious dietary deficiency disease which has been considered as mainly prevalent in the Orient, also occurs in the United States, according to Dr. Soma Weiss, Boston City Hospital. This disease is the result of a diet deficient in vitamin B, and it has been thought that its chief effect was on the nerves, resulting in the development of polyneuritis and mental disturbances. Doctor Weiss and his associate, Dr. Robert W. Wilkins, report that the disease is fairly common in this country, but it is generally mistaken for a disorder of the heart or blood circulation, and so has escaped recognition.

Alcohol plays a part in causing this condition, but lack of vitamin B in the diet is mainly responsible. These physicians made a study of 120 patients with symptoms of heart and blood vessel diseases and found that the cause of the ailment was faulty nutrition.

The condition is brought on by the following factors: low intake or utilization of vitamin B_1; high metabolism of the body occurring in increased caloric intake during fevers, hard muscular labor, pregnancy or hyperthyroidism; a diet rich in carbohydrates or alcohol. The disease occurs, in the northeastern part of the country, mainly among alcoholics, diabetics, pregnant women and food cranks. Clinical manifestations include rapid heart rate, palpitation, heaving cardiac impulse, enlargement of the heart, shortness of breath, asthma, engorgement of the veins, and transient heart murmurs. Rapid recovery, with disappearance of all abnormal conditions of the heart and blood, generally follows treatment with rest and a diet rich in vitamin B.

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FARM-FRESH . . . Harvested when at its flavor peak, then cleaned, sorted, packaged and quick-frozen right at the farm. Birds Eye Spinach reaches you farm-fresher in December than the kind on the market even in season!

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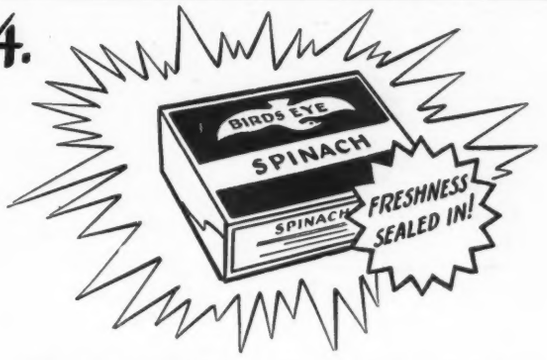

BIRDS EYE SPINACH is always dependable—always farm-fresh. The patented process of quick-freezing used for all Birds Eye Foods seals in the freshness and full flavor.

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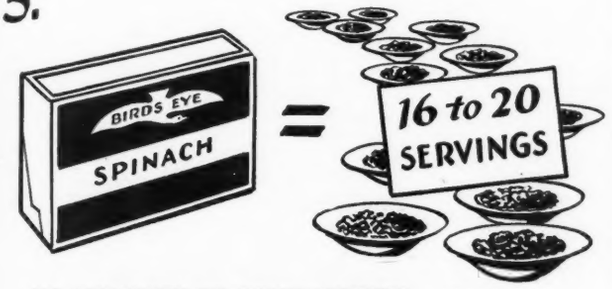

NO "BY-GUESS-BY-GOLLY" PROFITS . . . Each 40 oz. carton of Birds Eye Spinach gives you 16 to 20 servings. You can figure your portion cost to the fraction of a penny—you know in advance exactly how much profit you make on each individual person served.

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January Dinner Menus for the Small Hospital

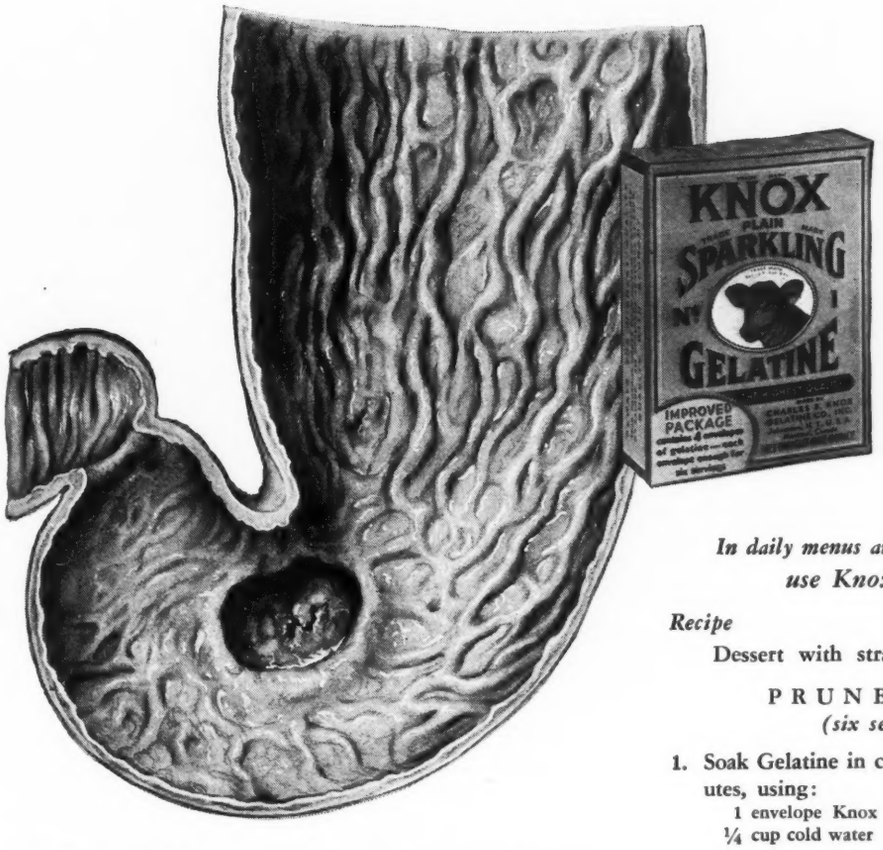
By Jane E. Smith

Dietitian, Chicago Memorial Hospital, Chicago

Day	Soup or Appetizer	Meat or Substitute	Potatoes or Substitute	Vegetable	Salad or Relish	Dessert
1.	Beef Broth	Baked Liver and Tomato Gravy	Browned Potatoes	Buttered Asparagus	Mixed Greens	Prune Whip
2.	Tomato Bouillon With Rice	Roast Beef au Jus	Baked Potatoes	Glazed Carrots	Lettuce Hearts, Roquefort Dressing	New York Cherry Ice Cream
3.	Vegetable Soup	Paprika Schnitzel	Parsley Potatoes	Baked Squash	Sliced Beet and Egg Salad	Gold Cake With Chocolate Frosting
4.	Duchess Soup	Lamb Chops	Buttered Rice	Spinach	Carrot and Raisin Salad	Baked Apples
5.	Oxtail Soup	Creamed Chicken	Baked Potatoes	Fresh Green Beans	Peach Salad	Butterscotch Pudding
6.	Chicken Broth	Beef Stew	Boiled Potatoes	Carrots, Turnips and Onions	Pineapple, Marshmallow and Nut Salad	Spice Cookies
7.	Fruit Juice	Baked Lake Trout	Mashed Potatoes	Broccoli With Drawn Butter	Lettuce, French Dressing	Chocolate Joy
8.	Cream Mushroom and Spinach Soup	Swiss Steak	Parsley Potatoes	Stewed Tomatoes With Okra	Cress and Endive Salad	Butter Cake With Mocha Frosting
9.	English Barley Soup	Baked Ham, Raisin Sauce	Baked Yams	Buttered Cauliflower	Celery and Olives	Black Walnut Ice Cream
10.	Hot Spiced Tomato Juice	Meat Loaf With Spiced Plums	Escalloped Potatoes	Harvard Beets	Carrot and Pea Salad	Blueberry Cobbler
11.	Mulligatawny Soup	Boiled Tongue	Creamed Potatoes	Swiss Chard	Rolled Celery With Pimiento Cheese	Raspberry Sherbet
12.	Beef Broth	Roast Lamb With Mint Jelly	Hashed Brown Potatoes	Wax Beans	Waldorf Salad	Coconut Cream Tarts
13.	Duchess Soup	Salisbury Steak on Toast		Mashed Yellow Turnips	Apple and Cabbage Salad	Chocolate Bread Pudding, Marshmallow Sauce
14.	Vegetable Soup	Baked Salmon	Mashed Potatoes	Buttered Cabbage	Pickled Beans	Cherry Pandowdy
15.	Fruit Juice	Veal Pie	Mashed Potatoes	Carrots, Onions and Peas	Cardinal Salad	Apricot Brown Betty, Butterscotch Sauce
16	Broth	Roast Duck With Stuffing	Mashed Sweets	Baked Squash	Cranberry Sauce, Celery Curls	Ice Cream With Sauce
17.	Tomato Bouillon	Ham Loaf, Spiced Crabapples	Potatoes Au Gratin	Stewed Beans	Molded Cranberry-Apple Salad	White Fruit Cake
18.	Pepper-Pot Soup	Meat Balls	Buttered Noodles	Creamed Asparagus	Grapefruit Sections With Pomegranate Seeds	Indian Pudding, Hard Sauce
19.	Beef Broth	Lamb Patties With Browned Pineapple	Mashed Potatoes	Lima Beans	Cinnamon Apple Salad	Poppyseed Cake
20.	Creamed Asparagus Soup	Roast Veal, Current Jelly	Baked Potatoes	Mashed Squash	Lettuce Salad	Lemon Pudding With Meringue Islands
21.	Cream of Tomato Soup		Baked Sweets	Julienne Carrots, Fried Egg Plant and Spinach	Cottage Cheese and Chive Salad	Dutch Apple Cake, Lemon Sauce
22.	Special Concord Grape Juice	Baked Pork Chops	Rice With Tomato Sauce	Buttered Peas	Golden Salad	Jelly Roll
23.	Chicken Gumbo	Chicken Shortcake		Broccoli With Drawn-Butter	Celery Hearts and Olives	Chocolate Peppermint Stick Ice Cream
24.	Duchess Soup	Lamb Stew	Buttered Potatoes	Carrots, Peas and Onions	Mixed Fruit Salad	Angel Food Cake
25.	Scotch Broth	Chinese Chop Suey	Chinese Noodles	French Green Beans	Sliced Tomato Salad	Graham Cracker Pie
26.	Pepper-Pot Soup	Pickled Ham	Candied Yams	Spinach	Pineapple-Tomato Salad	Steamed Fig Pudding, Fig Sauce
27.	Mulligatawny Soup	Corned Beef	New Parsley-Buttered Potatoes	Carrots, Turnip and Cabbage	Celery Hearts	Maple-Nut Pudding
28.	Cream of Spinach Soup	Baked Haddock	Delmonico Potatoes	Stewed Tomatoes	Perfection Salad	Rhubarb Tarts
29.	Cranberry Juice Cocktail	Ragout of Beef	Fried Rice	Brussels Sprouts	Curly Endive, French Dressing	Fruit Gelatin, Custard Sauce
30.	Consommé	Fried Chicken	Parsley Potatoes	Glazed Parsnips	Celery Curls and Radishes	English Toffee Ice Cream
31.	Chicken Broth	Breaded Veal Cutlets, Tomato Sauce	Mashed Potatoes	Buttered Asparagus	Sweet-Sour Red Cabbage Relish	Ambrosia

Recipes will be supplied on request by Anna E. Boller, The MODERN HOSPITAL, Chicago.

Knox Gelatine (U.S.P.) an Important Vehicle in GASTRIC DISTURBANCE DIETS



When advising a diet for gastric disturbances, remember that Knox Gelatine (U.S.P.) is a valuable vehicle. Knox Gelatine is not only an easily digested protein but blends with whatever foods are allowed into tempting salads and desserts.

In hyperacidity cases or in treating ulcers frequent meals are recommended. Jellied fruit juice or a bland, slightly sweetened gelatine dessert is a variant to the usual between meal beverage.

Knox Gelatine is scientifically made from selected long, hard, shank beef-bones — surpasses minimum U.S.P. requirements — pH about 6.0 — contains no carbohydrates — fat content less than 0.1% — odorless — tasteless — bacteriologically safe.

KNOX SPARKLING GELATINE

In daily menus and prescribed diets use Knox Gelatine

Recipe

Dessert with strained prune pulp.

PRUNE WHIP
(six servings)

1. Soak Gelatine in cold water about 5 minutes, using:
   1 envelope Knox Sparkling Gelatine
   ¼ cup cold water
2. Add to the following, stirring thoroughly:
   ¾ cup hot prune juice
   1 cup cooked prune pulp
   2 tablespoonfuls lemon juice
   ½ cup sugar
   ¼ teaspoonful salt
3. Cool. When mixture begins to thicken, fold in:
   2 egg whites, stiffly beaten
4. Rinse mold or dish in cold water, and fill with dessert. Chill. To serve, unmold and garnish with whipped cream, or serve with custard sauce.

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NEWS IN REVIEW . . . .

Basic Improvements for Cook County Hospital Recommended by Committee of Hospital Experts

Basic improvements in the organization, administration and service of Cook County Hospital, Chicago, were recommended by a committee of hospital experts who reported to the county commissioners last month.

Because Cook County Hospital is the largest institution of its kind in the world, special interest attaches to the report.

The committee was headed by Dr. Irving S. Cutter, dean, Northwestern University Medical School and superintendent, Passavant Hospital. Other members were: Veronica Miller, Henrotin Hospital; Rev. John W. Barrett, diocesan director of Catholic hospitals; Dr. A. C. Bachmeyer, University of Chicago Clinics; Asa Bacon, Presbyterian Hospital, and Charles A. Wordell, St. Luke's Hospital, all of Chicago.

Many conditions at the hospital are now unsatisfactory, in the committee's opinion. A few are highly dangerous to patients.

Among conditions especially listed are lack of centralized administrative control, the interference of politics in the selection of personnel, the badly neglected physical plant, the inadequacy of nursing personnel in certain divisions, the need for additional resident physicians and the necessity of limiting interns to work which they can safely perform, the disorganized and inadequately housed out-patient department, the crude admitting practices, the overworked and overcrowded x-ray department, the acute shortage of linen and the inadequate diets and lack of professional supervision of a large part of the food service.

"The chief executive officer of the hospital," the committee stated, "should be an administrator who has had experience in the management of a large hospital, preferably a large public general hospital. He should be a man who is well versed in the use of modern tools of management and who has shown marked executive ability."

Earlier in its deliberations the committee recommended the appointment of a committee of outstanding Chicago citizens to advise the county commissioners on appropriations, effectiveness of the management, policies, practices and plans for future development; to encourage public support of the hospital; to promote its development as a center of medical education and research, and to evolve a long-term program for the development of adequate facilities to meet future needs of the indigent sick of the county.

This committee, as appointed by the commissioners, includes Britton I. Budd, Walter J. Cummings, D. F. Kelly, Albert D. Lasker, Eugene McDonald, Jr., Victor A. Olander, Charles H. Schweppe, Col. A. A. Sprague and Gen. Robert E. Wood.

The survey committee also recommended use of approved voluntary hospitals to meet the overcrowding in Cook County Hospital, construction of a hospital for chronic diseases and a hospital for convalescents and adequately staffed ambulance service.

It recommended also that the hospital be divided into five services, four to be allocated to the four medical schools and the fifth to be available to physicians on the hospital staff who have no medical school appointment.

Colorado Association Warned Against Proposed Amendment

Warning against a proposed amendment to the Colorado state constitution making it mandatory for any hospital receiving state support or payments from government agencies to open its doors to osteopaths and chiropractors was made by Dr. H. A. Black, Parkview Hospital, Pueblo, in his presidential address before the Colorado Hospital Association meeting in Denver, November 9 to 10.

Robert Neff, administrator, University of Iowa Hospitals, Iowa City, was a guest speaker at the association banquet and at the morning session on November 9. Mr. Neff, the new president of the American Hospital Association, discussed aims and ideals of the national organization. Also on the program was E. A. Van Steenwyk, executive director, Minnesota Hospital Service Association, Minneapolis.

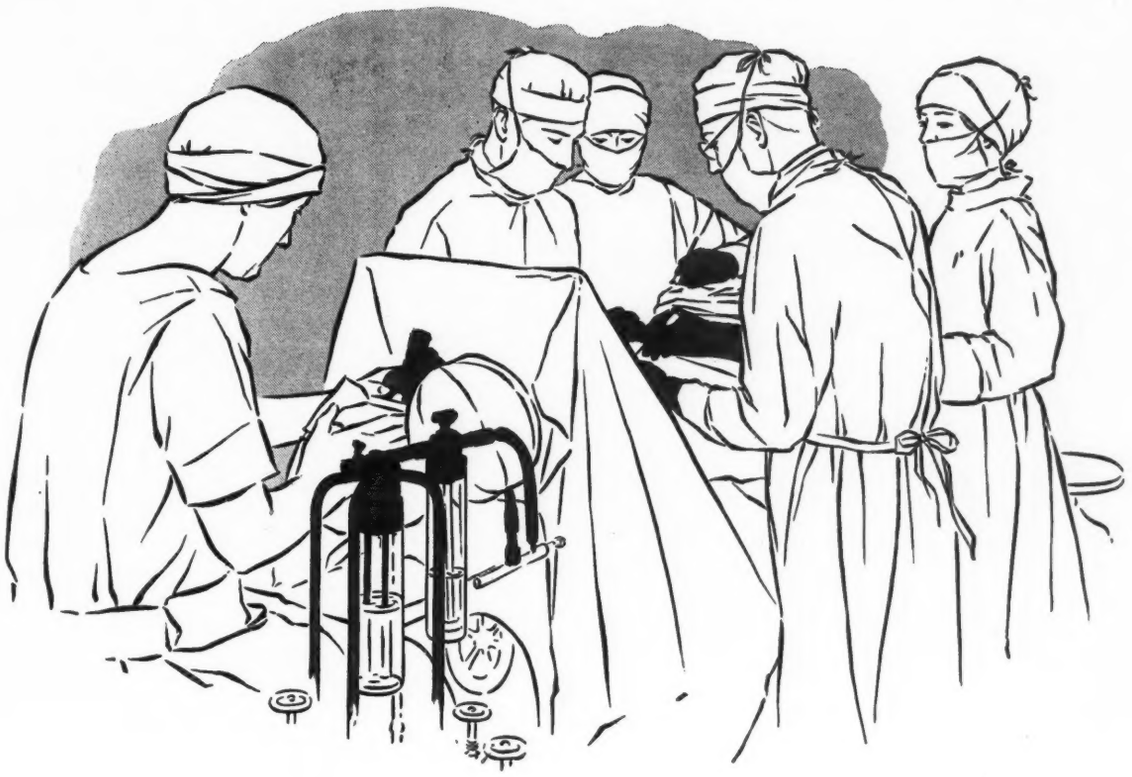
The Very Rev. Msgr. John R. Mulroy, director, Catholic Charities, Denver, was named president-elect of the association. R. J. Brown, Boulder-Colorado Sanitarium and Hospital, Boulder, was elected first vice president, and Walter G. Christie, administrator, Presbyterian Hospital, Denver, was named executive secretary of the association.

Ellis Hospital Campaign Oversubscribed

Ellis Hospital, Schenectady, N. Y., will proceed immediately with a building and remodeling program that will increase the hospital's capacity by 100 beds and substantially improve scientific departments.

The public was asked to subscribe $700,000, the largest fund ever sought by public subscriptions in the vicinity, but when the figures were tabulated at a final report meeting of volunteer workers, the total reached $845,069. This represented the gifts of more than 23,000 persons, or the equivalent of nearly one subscriber for every family residing in Schenectady. Post-campaign subscriptions have already increased the fund to $850,000.

A feature of the fund-raising program was the solicitation of memorial gifts equivalent to the cost of building and equipping departments, wards and rooms in the new building. More than 100 such gifts totaled $525,920.



THE ASEPTIC SURGICAL FIELD

THE basic requirement of modern surgery is asepsis. The choice of a suitable antiseptic is hardly less important than cleanliness and proper handling of instruments and supplies.

Bactericidal action may be obtained without undue tissue damage by the use of 'Merthiolate' (Sodium Ethyl Mercuri Thiosalicylate, Lilly). This antiseptic is suitable for all surgical indications and may be used to advantage in both clean and contaminated wounds.

Tincture 'Merthiolate,' an alcohol-acetone-aqueous solution, 1:1,000, is recommended for preoperative preparation of the intact skin.

Solution 'Merthiolate,' an isotonic aqueous dilution, is suggested for open wounds and for application in body cavities. Both tincture and solution are supplied in four-ounce, one-pint, and one-gallon bottles.

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Hospital Labor Troubles Are Renewed in Some Sections; Month on the Whole Is Quiet

The labor epidemic has broken out afresh in hospitals in different sections of the country. Notable among the cases reported are those of the attempted organization of employees of the Massachusetts State Department of Mental Diseases and also a drive to organize employees in all Veterans' Administration Facilities, both by sections of the A. F. of L., and the wholesale resignation of nurses from an Omaha hospital.

The union has attempted to reduce the work week of employees in Massachusetts mental hospitals to forty hours and to raise the wage rate of $10.50 weekly plus maintenance for attendants to $14 plus maintenance.

Dr. Clifton T. Perkins, the acting commissioner of the department, reminded employees that they had redress for labor difficulties through legislative and judicial channels, and that as employees of the commonwealth their allegiance should be solely to the public. Governor Curley upheld the commissioner by forbidding state employees from joining a labor organization whose constitution does not contain a "no-strike" clause, action regarded by the Massachusetts Federation of Labor as a violation of the National Labor Relations Act. Mr. Perkins said organization of hospital employees would result in an additional direct cost of more than $2,000,000, would add 1,300 employees to the department and would necessitate additional housing provisions.

Late in October the A. F. of L. also made a drive to improve working conditions in all Veterans' Administration Facilities which will provide hospitalization. Pay or compensatory time for overtime work, automatic promotion of Grade B attendants to Grade A after six months of service, relief from charges for quarters, subsistence and laundry when not actually on duty, and a full day for each legal holiday are among specific items that the American Federation of Government Employees is seeking.

Twenty-two nurses, the entire remaining staff of the Douglas County Hospital, Omaha, Neb., recently resigned because they were required to work "beyond endurance" since twenty-seven others had quit in the previous sixty days because the county had no funds to pay them. The nurses said they would return if the county gave them back pay in cash, a $10 a month increase and more help.

Michigan Disaster Speeds State Construction Program

A blaze ravaged one wing of the Newberry State Hospital, Newberry, Mich., recently, causing $100,000 damage and driving 110 patients from the burning building.

The cause of the blaze has not been determined, according to Dr. E. H. Campbell, hospital superintendent. Thirteen bedridden patients were carried to safety and eighty others were led from the building. Weekly fire drills were credited with the orderly manner in which rescues were made.

Aroused by this fire and another in the same week at the Livingston County Infirmary, Gov. Frank Murphy ordered Michigan's $3,000,000-a-year hospital construction and modernization program speeded up. The governor announced he had started plans that may develop into a long-term hospital construction program which will cost from $12,000,000 to $15,000,000.

To prepare for this program, the governor ordered the state budget director and administrative board secretary to make an inventory of capital outlay needed for long-term building and rejuvenation to fit state finances.

Visits to three institutions at Lapeer, Ionia and Wahjamega within the week convinced the governor that the state needed to improve facilities for medical research toward preventing and curtailing mental diseases.

"A common need of all our institutions is that they never have enough medical and scientific help," he said. "They get along with just enough for administrative needs. There are no provisions for research to help us in the field of preventive mental hygiene."

Inaugurate Rotating Internships

Four Des Moines hospitals in cooperation with the Polk County Medical Society of Iowa are inaugurating a rotating general internship service beginning July 1, 1938, and extending into a two-year internship July 1, 1939, the *Journal of the American Medical Association* reports. The hospitals associated in this plan are the Iowa Lutheran Hospital, Iowa Methodist Hospital, Mercy Hospital and Broadlawns, Polk County Public Hospital. Applications will be received from graduates of class A medical schools only. Rotation of service will include exchange between the individual private institutions, which the intern selects, and the county hospital. Pay is $25 a month and maintenance.

Osteopaths May Not Practice in Flint Municipal Hospital

Refusal of the board of managers of Hurley Hospital, Flint, Mich., to allow osteopathic practitioners to practice in the municipal institution was upheld recently in the local circuit court. The motion of two Flint osteopaths, asking a court order allowing them to refer patients to and practice in the municipal hospital, was dismissed by the judge. The court held that the board has the right to designate who may practice in the hospital as long as the designation is made by class and not against individuals.

Ralph M. Hueston, superintendent of the hospital, testified that the American College of Surgeons and the American Medical Association would refuse to approve the hospital if osteopaths practiced there.

Tumor Institute to Open in March

The Chicago Tumor Institute, a nonprofit research laboratory in the diagnosis and treatment of cancer will open around March 1. The institute will be directed by a scientific committee consisting of Dr. Max Cutler, former director of the tumor clinic at Michael Reese Hospital, Chicago; Dr. Henri Coutard of the Curie Institute, Paris; Sir George Lenthal Cheatle, London; Arthur H. Compton, Ph.D., professor of physics at the University of Chicago, and Dr. Ludvig Hektoen, director of the John McCormick Institute for Infectious Diseases, and recently appointed member of the council of the National Cancer Institute. One of the important functions of the institute is to train physicians and surgeons desiring to specialize in the diagnosis and treatment of cancer. Although the scope of the institute will be national, contributions have been made entirely by Chicago citizens.

Cruise Congress Dates Announced

Dr. C. W. Munger, who is president of the section of public health, medical education and hospitals of the Pan-American Medical Association, has announced that the sailing date for the seventh cruise congress to Havana and the West Indies will be on January 15 from New York City. The *S. S. Queen of Bermuda* has been chartered for the voyage. The main part of the congress will be held in Havana where there will be three days of scientific sessions.

Installs Ice Plant

A new ice plant recently was installed by the Grace Hospital of New Haven, Conn., at a cost of $5,500, replacing the old one which served the hospital eighteen years.

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Provisions for Medical Care Are Presented by 430 Prominent Physicians and Surgeons

On November 7 a committee of physicians representing 430 doctors and surgeons throughout the country presented to medical organizations principles and proposals for the provision of medical care to which 430 have subscribed.

Both the draft of principles and signatories were made public by Dr. John P. Peters, professor of internal medicine at Yale University, and secretary of the committee of physicians, of which Dr. Russell L. Cecil, associate attending physician, New York Hospital, is chairman.

The origin of the draft was in the report of the American Foundation Studies in Government, entitled "American Medicine: Expert Testimony Out of Court." It is the consensus among these physicians that "medicine must be mobile and not static if medical men are to act as the expert advisers of those who convert public opinion into action."

The principles signed by the 430 prominent doctors and now presented to the medical organizations for consideration, are:

1. That the health of the people is a direct concern of the government.
2. That a national public health policy directed toward all groups of the population should be formulated.
3. That the problem of economic need and the problem of providing adequate medical care are not identical and may require different approaches for their solution.
4. That in the provision of adequate medical care for the population four agencies are concerned: voluntary agencies, local, state and federal governments.

The nine proposals advanced are as follows: (1) the risk of illness should be minimized by prevention; (2) the immediate problem for provision of adequate medical care should be met from public funds; (3) public funds should support medical education and studies for raising the standards of medical practice; (4) public funds should be available for medical research; (5) public funds should be made available to hospitals rendering service to the indigent and for laboratory and diagnostic and consultative services; (6) allocation of public funds to existing private institutions utilizes them to the largest extent; (7) public health services should be extended by evolutionary process; (8) investigation and planning of measures proposed and their direction should be assigned to experts, and (9) government health and medical services should function under a separate department.

Signatories of these proposals included a list of doctors prominent in every branch of medicine. Among the hospital administrators are: Dr. Nathaniel W. Faxon, Massachusetts General Hospital, Boston; Dr. Arthur J. Lomas, University of Maryland Hospital, Baltimore; Dr. Charles F. Wilinsky, Beth Israel Hospital, Boston, and Dr. Frederic A. Washburn, Cambridge Hospital, Cambridge, Mass.

In a statement issued November 21, the American Medical Association states that the mandate given by its house of delegates opposes these principles and proposals, and also some new proposals from another self-appointed group suggesting enabling legislation for sickness insurance. If the house of delegates sees fit to depart from the principles now established, it will be the duty of the trustees, officers and employees of the A. M. A. to promote such new principles as are established, the official statement declares. In the meantime, the medical association asserts that it "will deprecate any attempts inclined to lead the executive and legislative branches of the government, as well as the people of the United States, into the belief that the American medical profession is disorganized."

What's Doing on Group Hospitalization Front

Last May when legislation finally was effected in Georgia permitting group hospitalization for employed groups, Atlanta hospitals immediately applied for a charter which was granted in June. During October the hospitals of Atlanta officially accepted this charter and elected directors to promote the plan, known as the United Hospitals Service Association of Atlanta. C. J. Anderson is the executive director of the plan.

This action of Atlanta hospitals marks another milestone in the progress of group plans for hospital care. This association comprises five hospitals, the Crawford W. Long Memorial Hospital, Emory University Hospital, Georgia Baptist Hospital, Piedmont Hospital and St. Joseph's Infirmary.

The period of hospitalization for a subscriber is not to exceed twenty-one days, and the rate is $9 a year for a ward bed and $12 a year for a private room. The fee includes laboratory service up to $10 and drugs up to $5 for any one period.

The Rochester Hospital Service Corporation of Rochester, N. Y., continues to attract attention throughout the country as one of the most successful, nonprofit community programs in existence. On Sept. 1, 1937, 23 per cent of the population of Rochester were protected as subscribers or dependents by contracts of this plan. Rochester's plan now has 78,997 persons ensured, representing 756 employee groups.

As Chicago's Plan for Hospital Care passed the 25,000 enrollment mark, its executive director, Perry Addleman, reported that more than 1,000 patients have received care under the plan, which enters its second year January 1.

Fairmont, Minn., with a population of approximately 4,000, is being offered a cooperative hospital plan through the Fairmont Clinic and Hospital, local clubs and medical practitioners.

At Syracuse, N. Y., the one-and-one-half-year-old group employee plan has been extended to include family groups. The new coverage is for the immediate families of present employed subscriber group members or new members of such groups. An additional charge of 22 cents a week to the individual charge of 15 cents a week is made for family benefits. The family plan provides at 37 cents a week the same hospital protection offered individual subscribers, with a limitation of maternity service to ten days.

The service affords free choice of a hospital among participating hospitals, free choice of a physician and covers hospital bills for the period stated under the contract. It does not include the fees of the doctor, special private nursing, x-ray, electrocardiograms, metabolism tests, physical therapy or blood chemistry tests.

Group hospitalization in Pittsburgh and western Pennsylvania actually came nearer to realization last month with the appointment of Maurice Norby and Abraham Oseroff as directors of the hospital insurance plan. Mr. Norby, who formerly was associated with the Minnesota Hospital Service Association, will devote full time to the new plan. Mr. Oseroff will continue as director of Montefiore Hospital in Pittsburgh but will exercise supervisory direction over the plan, at least in its early stages.

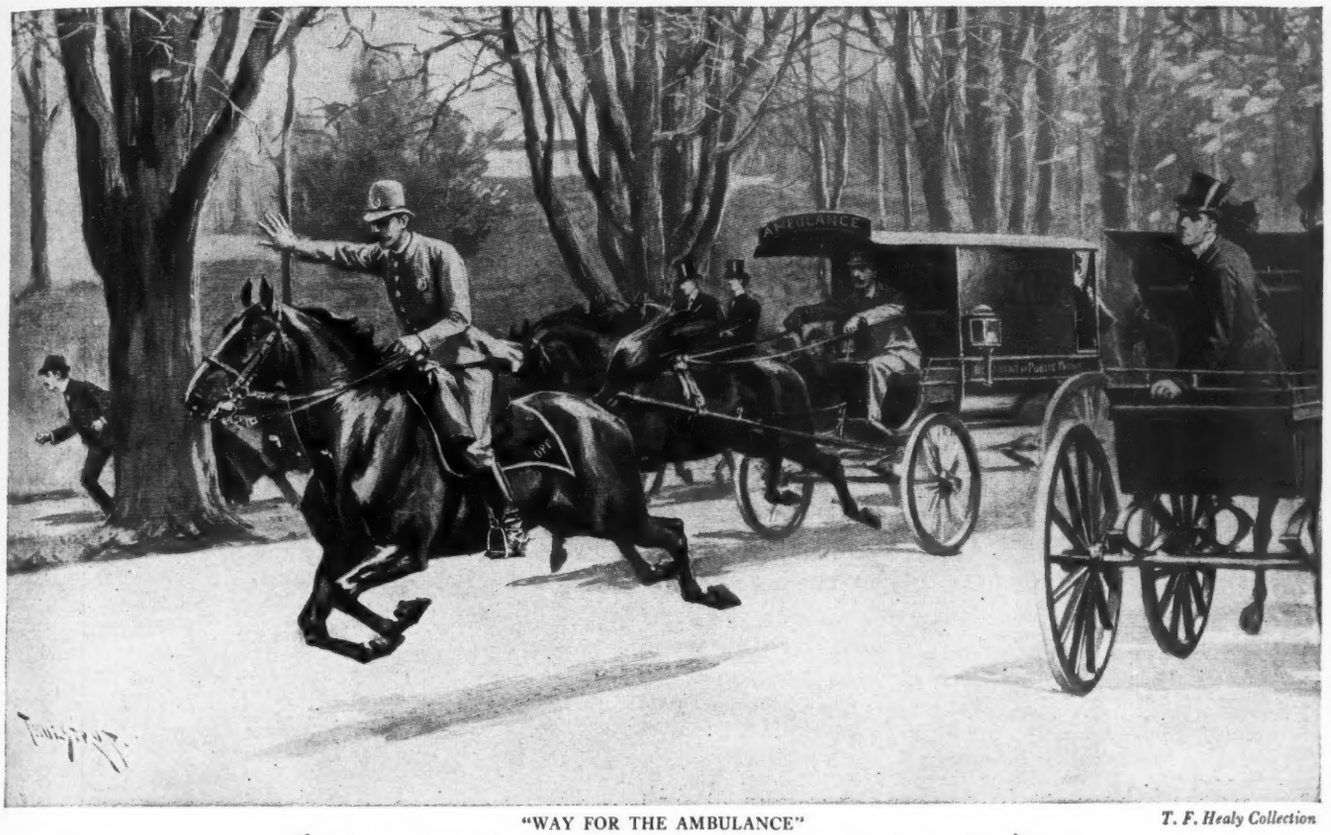
Already a substantial group of hospitals in western Pennsylvania have indicated their interest in the plan and their intention of becoming hospital members.

Hospital Changes Name

The name of the Chicago Fresh Air Hospital has been changed to the Birchwood Park Sanitarium, since the hospital has gradually changed during the past few years to include patients suffering from diseases other than tuberculosis.

From Hoof-beats to Shrill Sirens

Hospitals Have Used Webb's Alcohol



"WAY FOR THE AMBULANCE" *T. F. Healy Collection*

The same excitement that thrills onlookers today, as an ambulance races by, stirred bystanders in 1895. Today a siren clears the way. Then, a horseman, as in the above scene in Central Park, New York, performed this function by shouting "Way for the ambulance."

MANY physicians still remember the horse-drawn ambulance of the gay nineties. Some may even recall the horseman galloping ahead crying "Way for the ambulance!"

Those who remember the old ambulance certainly will remember Webb's Alcohol. For long before horses gave way to gasoline, the name of Webb was a byword for dependable alcohol. Hospitals knew that James A. Webb and Son had been making highest quality alcohol since 1835. That was why each generation could give it the stamp of approval.

In 1915, when the gasoline buggy was coming into its own, the priceless eighty years' experience of the Webb family was added to the vast technical knowledge of the U. S. Industrial Alcohol Co. This wedding of experience and modern methods enables U.S.I. to uphold the Webb tradition and to manufacture highest-quality alcohol of a grade particularly suited to hospital and pharmaceutical use.

For over 100 years, hospitals have relied on Webb's Alcohol. Today, American hospitals use more Webb's and U.S.I.-U.S.P. Alcohol than any other single brand. To meet the exacting requirements of modern medicine, specify Webb's or U. S. I.-U.S.P. Alcohols.

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A. C. S. Hears Plan to Provide Small Hospitals With Experienced Heads; Also Other Proposals

A plan whereby small hospitals, frequently remote from large medical centers, may have the advantages of highly trained and experienced administrators at a price they can afford to pay was advanced at the twentieth annual Hospital Standardization Conference, held in conjunction with the sessions of the American College of Surgeons in Chicago, October 25 to 29.

In outlining this larger field of service, its originator, Dr. Allan Craig, medical director of the Eastern Maine General Hospital, Bangor, claimed that this idea is completely in line with the trend to centralize other special services of hospitals, such as laboratory and x-ray.

"There is no reason why a trained hospital executive could not be responsible for the administration of a small group of hospitals within a small area, having an assistant constantly on the job in each hospital," Doctor Craig averred.

"By pooling our administration in neighboring small institutions, each one of those hospitals in the group would have the advice, direction and service of a trained administrator at all times at a reasonable cost," he continued, at the same time emphasizing that he did not mean to infer that small hospitals are being incompetently managed.

New problems relating to personnel, to public relations and to provisions for coping with the increasing shortage of adequately trained nurses received the full attention of administrators during the conference.

Out of 3,575 hospitals surveyed, 2,621 were placed on the approved list of the American College of Surgeons, the report of Dr. George Crile, chairman of the board of regents, showed. The survey also indicated that new supplies and equipment approved by the college have been adopted as fast as they have been available. There is a growing trend toward improvement of services that recognize the individual differences of patients and toward the application of practical psychology.

A recommendation that 2 per cent of the hospital budget be earmarked for publicity or for intelligent promotion of public relations was made by Perry Addleman, Chicago, executive director of the Hospital Service Corporation. This money, Mr. Addleman pointed out, would be returned to the hospital multiplied many times from sources such as better collections, increased financial support and the intelligent use of hospital services by the public.

Several means of keeping the public interested in the hospital and its facilities were presented by Ada Belle McCleery, the superintendent of the Evanston Hospital, Evanston, Ill. She particularly favors the house organ, which should present the hospital's point of view. This should be edited by a trained and paid editor, Miss McCleery said, in cooperation with the entire staff.

"If hospitals are to have a well-rounded public relations program," declared Miss McCleery, "the administrator must carry his part of the load. He should have at least a few original ideas and a great deal of driving power."

Recommendations for increasing the number of carefully trained nurses, made during a panel round table on administrative problems, included the opening of training schools now closed, better provisions for postgraduate work, higher entrance requirements and the establishment of a minimum wage.

The function of social service in the hospital, particularly in those having a high percentage of charity cases, was outlined by Mrs. Babette Jennings, director of the social service department of Children's Memorial Hospital, Chicago.

General and children's hospitals need more departments of oral and dental surgery because of the accepted relationship between dental focal infection and systemic diseases, said Dr. William H. G. Logan, dean of the Chicago College of Dental Surgery. Other topics that received consideration during the sessions included air conditioning, centralized food service, the hospital pharmacy, the out-patient department and various clinics.

A series of demonstrations in twenty Chicago hospitals included many phases of routine procedure and such specialties as fever and oxygen therapy, medical records, central treatment and psychiatric services.

Miss McCann Taken by Death

Anna T. McCann, office manager of the American Hospital Association, died on November 28 of leukemia. Out of respect for Miss McCann the headquarters office of the association remained closed the day following her death. Burial was in Youngstown, Ohio. Miss McCann, through her work at the registration booth at A. H. A. conventions and through her courtesy to all visitors to the A. H. A. offices was widely known and respected throughout the hospital field. She had been with the association for eighteen years and was a distinct factor in the upbuilding of the organization.

Lillian Erickson Named President-Elect of R. L. N. A.

The Record Librarians of North America, convening in Chicago concurrently with the clinical congress of the American College of Surgeons, October 25 to 29, elected Lillian Erickson of the Milwaukee Children's Hospital, president-elect of the association. Jennie Jones, Maryland General Hospital, Baltimore, will head the association next year. Helen Hayes, St. Alexis Hospital, Cleveland, was named treasurer; Margaret Neale, Colorado General Hospital, Denver, recording secretary, and Sylvia Maness, New England Hospital for Women and Children, Boston, corresponding secretary.

The remunerative value of good medical records was pointed out in a talk by Dr. R. B. Davis, Greensboro, N. C., who cited their value in making collections and in bringing patients back regardless of the time that has elapsed between illnesses and the distances to be traveled.

Other papers were given upon appraisals by medical records by Miss Erickson and Dr. Charles B. Puestow of Chicago; on the causes and remedies of incomplete records by Alice G. Kirkland, Samuel Merritt Hospital, Oakland, Calif; on developing record consciousness in the hospitals by Sister M. Patricia, St. Mary's Hospital, Duluth, Minn., and on group disease studies, by Dr. T. R. Ponton, Chicago.

Minnesota Hospital Institute

The second Minnesota Hospital Institute will be held at the University of Minnesota, January 26 to 28. Dr. A. F. Branton, chairman, will be assisted by Ray Amberg. A large attendance is predicted.

She's a Pay Patient Now

A seventy-two-year-old woman was admitted to the paupers' ward of the Los Angeles County General Hospital after her physician had found her senseless on the floor of her modest residence.

Admitted to the paupers' ward, since she always had maintained she was penniless, the elderly woman was placed in a bed. Nurses tenderly undressed her.

Next to her body they found a money belt. When opened, it was found to contain:

Seventeen $1,000 bills and eight rings, in six of which were set large diamonds.

Hospital authorities immediately ordered her removal to Hollywood Hospital, where she was reported recuperating in a private room.

Increased Community Chest Support Indicated for Third Year From Early Campaign Reports

Early campaign reports from forty-five of the 375 community chests holding annual financial campaigns during the fall months indicate that for the third year chest support is on the upgrade. A total increase of 2.5 per cent over the amount raised last year by these chests has been noted. To date these forty-five chests have raised $6,551,693 for 1938, representing 96.5 per cent of their announced goals. Thirty-three chests of this group have reached their goals or raised more than for 1937.

Among the large cities reporting so far are: Milwaukee, which has raised thus far $1,057,056 this year for 1938, as compared to $1,003,619 for 1937; St. Paul, which has raised $741,000 for 1938, as compared to $743,150 for 1937; Indianapolis, which has raised thus far $707,497 for 1938, as compared to $700,017 for 1937; Honolulu, which raised $532,176 for 1938, as compared to $535,016 for 1937; Erie, Pa., which raised $348,938 for 1938, as compared to $346,381 for 1937, and San Diego, Calif., which has raised thus far $223,017 for 1938, as compared to $216,687 for 1937.

Hospitals received 10.5 per cent of the total appropriations of all national community chests during 1937, it has been estimated on the basis of reports from ninety-six community chests in the larger cities. These ninety-six cities raised more than one-half of the $80,000,000 total raised by all chests for this year. An additional 10.8 per cent went for other health services, including nursing care, during 1937.

Chest-supported hospitals are now receiving about 8 per cent more income from all sources than in 1929, and are the only group of chest agencies having a total income larger than in 1929, according to Allen T. Burns, executive vice president, Community Chests and Councils, Incorporated. "This is true in spite of the fact that chests are giving hospitals, for 1937, less money than in 1929," Mr. Burns said. "Hospitals have had a new and increased income from tax support in recent years; chests and member hospitals have joined together in requesting local government payments for the care of the indigent sick.

"For example, the Cleveland Community Fund and Welfare Federation have campaigned for public approval of special welfare tax levies which have resulted in the payment of $500,000 to voluntary hospitals for the care of indigent patients. Payments to the hospitals by the fund have been decreased by this amount. Other notable instances of this trend are seen in the policy of both Illinois and New Jersey which use state relief funds to pay for indigent patients in voluntary hospitals.

"In spite of the 20 per cent decrease in chest support and 20 per cent decrease in number of pay patients between 1929 and 1935, hospitals were able to increase their care of free patients 50 per cent. The explanation for the continued drop of hospital income from chests during a period showing increased service and increased need for support lies in the greater income hospitals are getting from other sources. Such income amounts to from six to eight times as much as income from chest contributions.

"A factor which must be considered in connection with these changes in hospital income is the group hospitalization insurance payments, some of which were undoubtedly formerly included in the patient-days paid for by the chest. Another factor to be considered is the change in basis of appropriation, per diem instead of deficit payment, which is growing in popularity as a basis for determining hospital receipts from both the chest and the public sources."

Record Keeping, Treatments Discussed at N. J. Meeting

Keeping patients' records and new treatment techniques were main topics discussed at the autumn conference of the New Jersey Hospital Association November 17 at the Hackensack Hospital, Hackensack, N. J.

The conference opened with a luncheon and was followed by a session on patients' records at which John R. Howard, Jr., superintendent, Muhlenberg Hospital, Plainfield; Dr. Andrew J. McBride of the medical staff of St. Joseph's Hospital, Paterson; Dr. August S. Knight, president, Somerset Hospital, Somerville, and Wendell J. Wright, trustee of Hackensack Hospital, were speakers.

New treatment techniques discussed were hypoglycemic shock therapy for the psychotic patient by Dr. J. Berkeley Gordon, medical director, New Jersey Hospital, Marlboro; the use of carbon dioxide for deep breathing, Mae Stone, anesthetist, Presbyterian Hospital, Newark, and use of the Hubbard tank in underwater therapy treatment, Dr. Spencer T. Snedecor, medical staff, Hackensack Hospital. Dr. Edward Guion is the new president of the association. Eleanor E. Hamilton presided.

New York United Hospitals Campaign by Photography

Last year more than $9,534,812 worth of free care was given to ward patients in the ninety-two member hospitals of the United Hospital Fund of New York City.

This announcement was made to 50,000 New Yorkers through a pamphlet, "Life, Health and Hospitals," distributed by the telegraph messenger boys. In size and form the pamphlet resembles *Life;* it was edited by Myron Weiss, medical editor of *Time.*

"Acres of Babies" in the nursery of one of the hospitals is the cover picture. Photographs show that the voluntary hospitals care for the sick and, in addition, train doctors and nurses and carry on investigations that protect the health of the community.

It is pointed out that "invested in these hospitals is $200,000,000. This is not an investment alone in plants and buildings, but an investment in the daily life and health of the entire community" and to keep this investment "the hospitals must have $3,171,134" to care for immediate needs.

Coming Meetings

Council on Medical Education and Hospitals, American Medical Association.
Next meeting, Chicago, Feb. 14-15.

Association of Western Hospitals.
Next meeting, San Francisco, Feb. 28-Mar. 3.

Western Conferences of the Catholic Hospital Association.
Next meeting, San Francisco, Feb. 28-Mar. 3.

Association of California Hospitals.
Next meeting, San Francisco, Feb. 28-Mar. 3.

New England Hospital Association.
Next meeting, Boston, March 10-12.

Ohio Hospital Association.
Next meeting, Columbus, April 5-7.

Southeastern Hospital Conference.
Next meeting, Birmingham, Ala., April 7-9.

Alabama Hospital Association.
Next meeting, Birmingham, April 8.

Mississippi Hospital Association.
Next meeting, Jackson, April 18.

Mid-West Hospital Association.
Next meeting, Kansas City, Mo., April 21-22.

American Nurses' Association, National Organization for Public Health Nursing and National League of Nursing Education.
Biennial convention, Kansas City, Mo., April 24-29.

Iowa Hospital Associataion.
Next meeting, Burlington, April 25-27.

Pennsylvania Hospital Association.
Next meeting, Pittsburgh, April 27-29.

Pennsylvania Association of Nurse Anesthetists.
Next meeting, Pittsburgh, April 27-29.

Pennsylvania State Dietetic Association.
Next meeting, Pittsburgh, April 27-29.

Tri-State Hospital Association (Indiana, Illinois, Wisconsin).
Next meeting, Chicago, May 4-6.

Hospital Association of New York State.
Next meeting, Buffalo, May 18-20.

New Jersey Hospital Association.
Next meeting, Jersey City, June 2-4.

Canadian Nurses Association.
Next meeting, Halifax, N. S., July 4-9.

Ontario Hospital Association.
Next meeting, Toronto, Oct. 19-21.

Cleveland City Hospital Starts Second Century With Politically Clean Hands Under Civil Service

On Oct. 18, 1837, the city council of Cleveland, then a city with a population of 5,000 people, passed an ordinance proclaiming that the township poorhouse was thereafter to be known as the city hospital.

On Oct. 18, 1937, the city hospital entered upon its second century politically free, as a progressive hospital operating under a tamperproof merit and civil service plan put into effect by Supt. James A. Hamilton.

Two years ago the incoming administration was confronted with a politically honeycombed and run-down institution, its staff demoralized, its superintendent, who resisted political machinations, ousted, and its budget cut below subsistence level.

First step in the rehabilitation program was the hiring of Superintendent Hamilton, then assistant professor of business administration at Dartmouth College, and for ten years head of the Mary E. Hitchcock Memorial Hospital there.

Reclassifies Employees

In nineteen months after Mr. Hamilton came to Cleveland, the last vestiges of the old political order were swept away. Just prior to the anniversary celebration the superintendent's plan for reclassification of hospital employees under civil service and the institution of a promotional system was approved by the civil service commission.

With adoption of the civil service program, 800 unclassified jobs were wiped out and all but 200 of the 1,200 hospital employees were placed under civil service. The 200 are unskilled laborers and student workers.

A budgetary increase has jumped the figure of $2.66 spent per patient per day for 1934 to $3.20 per day. Mr. Hamilton hopes to increase the figure to $4.42. Last May the city board of control granted an average 10 per cent pay increase to all of the hospital's 1,300 employees, halting an exodus of nurses and technicians to better-paying positions. A recent additional grant of $40,000 has enabled the hospital to remedy serious defects in hospital equipment.

Proclamation by the mayor designated October 18 as City Hospital Day, observed by an anniversary program of open house and an anniversary dinner at the Hotel Cleveland. Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics, was the principal speaker at the dinner, presided over by Dr. Winfred G. Leutner, president of Western Reserve University.

As the sixth largest hospital in the country, the $8,000,000 institution has sixteen buildings and an annual budget of $1,600,000 as compared to the original $5,000 appropriated for annual expenses when the hospital opened one hundred years ago.

Today the hospital has a resident staff of eighty-nine doctors and a visiting staff of 125. In 1837, two doctors visited the city hospital once or twice a week.

Today the hospital takes care of 15,000 persons a year. During 1837 some one hundred men and women were treated.

Albert G. Hahn Elected Secretary of Tri-State

Albert G. Hahn, executive secretary of the Indiana Hospital Association, has also been chosen as executive secretary of the Tri-State Hospital Assembly, comprising the associations of Indiana, Illinois and Wisconsin. Mr. Hahn succeeds Edward Rowlands, who was forced to resign because of increased duties at his own hospital.

The executive committee of the Tri-State Hospital Assembly has been increased from six members to nine, three from each state. In addition to the president and secretary of each state association, one other member has been appointed, Dr. R. C. Buerki for Wisconsin, Mr. Rowland for Illinois and J. B. H. Martin for Indiana.

The executive committee has decided to move the assembly from the Sherman Hotel to the Stevens Hotel in order to increase the space available for the exhibit. It will be held next year on May 4, 5 and 6.

Annual Dietetic Meeting Outstanding in Three Ways

The twentieth annual meeting of the American Dietetic Association, held in Richmond, Va., October 17 to 23, combined excellent meetings, southern hospitality and southern food to make one of the most outstanding conventions the association has held.

Controversy arose as to whether the teaching outline for nurses should be set up on a meal planning or some other basis at the professional education section meeting. Types of examinations and movies as a teaching technique were discussed.

O. K. Fike, business manager, Grace Hospital, Richmond, in a talk before the general session, proclaimed the dietitian the master salesman for the hospital.

The administrative section meeting was comprised mainly of reports on various phases of administrative work, including a report by Grace Augustine, Teachers College, Columbia University, on "Labor Policies in Nonprofit Institutions."

One of the outstanding general sessions was the pellagra symposium, at which slides and motion pictures were presented upon clinical and research aspects of the subject.

Lenna F. Cooper, Montefiore Hospital, New York City, took office as president of the association, and the following officers were elected for the coming year: Anna Tracy, Florida State College, Tallahassee, president elect; Beula Becker Marble, Huntington Memorial Hospital, Boston, vice president; Ruth Kahn, Washington University Medical School, St. Louis, secretary, and Sarah Elkin Braun, Mandel Clinic, Michael Reese Hospital, Chicago, treasurer.

Section chairmen elected were as follows: Adeline Wood, Mount Sinai Hospital, New York City, administration section; Mary Foley, Kahler Corporation, Rochester, Minn., diet therapy section; Helen Walsh, Los Angeles County Relief Administration, community education section, and Dr. Helen Mitchell, Amherst College, Amherst, Mass., professional education section of the association.

Discuss Prepaid Hospital Service

Prepaid hospital service was the chief topic on the program of the Massachusetts Hospital Association meeting held October 29 in Boston. Three speakers discussed this topic at the dinner meeting, Dr. Nathaniel W. Faxon, director, Massachusetts General Hospital and Massachusetts Eye and Ear Infirmary, Boston; Otto F. Bradley, executive director, Community Federation of Boston, and Reginald F. Cahalane, executive director, Associated Hospital Service Corporation of Massachusetts. In addition, Edward E. Rice, insurance counsel, discussed retirement pensions for hospital employees, at the dinner. A round table discussion also was held at the dinner. The afternoon program of the one-day meeting was composed of demonstrations at Boston hospitals.

Reviews Five Years' Progress

Five years of accomplishment were reviewed by the Association of Private Hospitals of New York City recently at a dinner celebrating the event. The association, the first of its kind in the United States, was organized to improve conditions and to standardize operation of proprietary hospitals in Greater New York, and now has a membership of twenty-one hospitals. Dr. Harold Hays, who has been president of the association since its beginning, was presented with a gift in appreciation of his work.

NEW BUILDING PROJECTS

PHOENIX, ARIZ. — Construction of the second phase of an extensive building program at the state hospital will be started soon with erection of a hospital building, expected to cost about $95,000; an occupational therapy building, $26,000, and a porch addition to the present women's ward, $9,000. Equipment will cost $15,000.

DENVER, COLO.—Erection of a seven-story $200,000 nurses' home for St. Luke's Hospital has begun here. Designed by Frank W. Frewen and Earl C. Morris, Denver architects, the new building will be modernistic in design, faced with brick and opaque glass.

WINTER HAVEN, FLA.—Contract has been awarded for construction of a new twenty-seven-bed hospital at a cost of $44,163. Work was expected to be started within ten days.

BOISE, IDAHO.—Lava Hot Springs has been chosen as the site of a new $208,000 Idaho state tuberculosis hospital. Plans for the three-story, brick structure are being prepared by the Boise architectural firm of Tourtellotte and Hummel.

BOSTON, MASS.—The federal government has acquired a 12-acre tract of land in Brighton, within the limits of Boston, for the site of the 300-bed Boston Marine Hospital for which $2,500,000 has been appropriated. The acquisition of the land by the government involved two transfers. The Commonwealth of Massachusetts transferred to the Massachusetts Memorial Hospitals more than twenty-two acres. In the same transaction the Memorial Hospitals conveyed to the government the twelve acres of land. The price paid for the tract was $210,000.

NEW YORK, N. Y.—A new nurses' home, costing $1,800,000, will gather the nursing personnel of Kings County Hospital under one roof early in 1938, officials of the department of hospitals have announced. Only 200 of the 800 nurses have been accommodated in the old buildings. The remainder were forced to live outside the nurses' residence. The new ten-story brick structure will house 600 nurses. The new home also will double the number of nurses in training, restricted in the old home to 120 students.

TOLEDO, OHIO.—Construction on the new $250,000 convalescent Home for Crippled Children has reached the half-way mark. The quarter-million-dollar figure is said to represent rock bottom building prices, since general contractors and all subcontractors and materials firms are supplying labor and materials at actual cost.

WAYMART, PA. — Ground breaking ceremonies were held recently for the $1,370,000 building program at the Farview State Hospital for Criminal Insane. Gov. George H. Earle's determination to eliminate overcrowded conditions in state-supported institutions and the federal government's cooperation in appropriating 45 per cent of the cost of the state's building program were told by prominent speakers.

CHATTANOOGA, TENN.—Construction of a new city-county hospital, for which the PWA recently granted $490,090, must be begun by Jan. 18, 1938, in order to comply with the PWA grant. The total cost of the structure will be $1,000,000.

BEQUESTS AND GIFTS

SAN FRANCISCO, CALIF. — Approximately $700,000 in cash, in addition to stocks and property of unestimated value, part of which went to hospitals and charitable institutions, was left under the will of the late William W. Carson, lumberman. Sums of $50,000 each were left the University of California Hospital, the Stanford Lane Hospital of San Francisco, and Shriners' Hospital for Crippled Children, San Francisco. The San Francisco community chest received $20,000.

LEBANON, OHIO.—A $40,000 fund to be used in construction of building projects at the Warren County Orphans' Home has been bequeathed by the late John W. Scull of Mason. A division of the remainder of the estate will be made between the Methodist Home for the Aged and Christ Hospital of Cincinnati.

PHILADELPHIA, PA.—A gift of $200,000 will enable the University of Pennsylvania Hospital to create a new radiologic and x-ray department for the study of malignant diseases. The gift was made by William H. Donner of Villanova, Pa., former president of the Donner Steel Company, who founded the International Cancer Research Foundation in 1932 by a gift of $2,000,000.

Maintains Cardiac Clinic

Over a period of almost two years, 135 children suffering with incipient heart disease have been treated in the cardiac clinic of the Lymanhurst Health Center, Minneapolis, maintained by the WPA, under auspices of the city division of health. The hospital occupies a floor of the health center and includes two wards of twenty beds each, a study room, children's dining room, library, enclosed porch for play, diet kitchen, electrocardiograph room, a two-bed isolation ward and an administrative suite. Dr. F. E. Harrington is administrator.

Commonwealth Fund Grants Sum for Hospital Course

A grant to the University of Chicago was announced by the Commonwealth Fund last month for the purpose of continuing the graduate course in hospital administration that has been offered at the school of business for the last three years.

This grant will be used for instruction, the preparation of study material, and fellowships and scholarships. Upon receipt of this grant the university announced that the course would be resumed at the beginning of the winter quarter, January 3.

Already a large number of applications for entrance in the course are on file, although only eight students can be accepted in any one year. The course is open to physicians, laymen and nurses holding the university entrance requirements of a bachelor's or doctor's degree.

By action of the university it was agreed that the course should be given in cooperation with the American College of Hospital Administrators.

Dr. Arthur C. Bachmeyer, director of the University of Chicago Clinics, will direct the hospital administration course. Gerhard Hartman, acting executive secretary of the American College of Hospital Administrators, will serve as associate director of the course at the university.

Clears Indebtedness

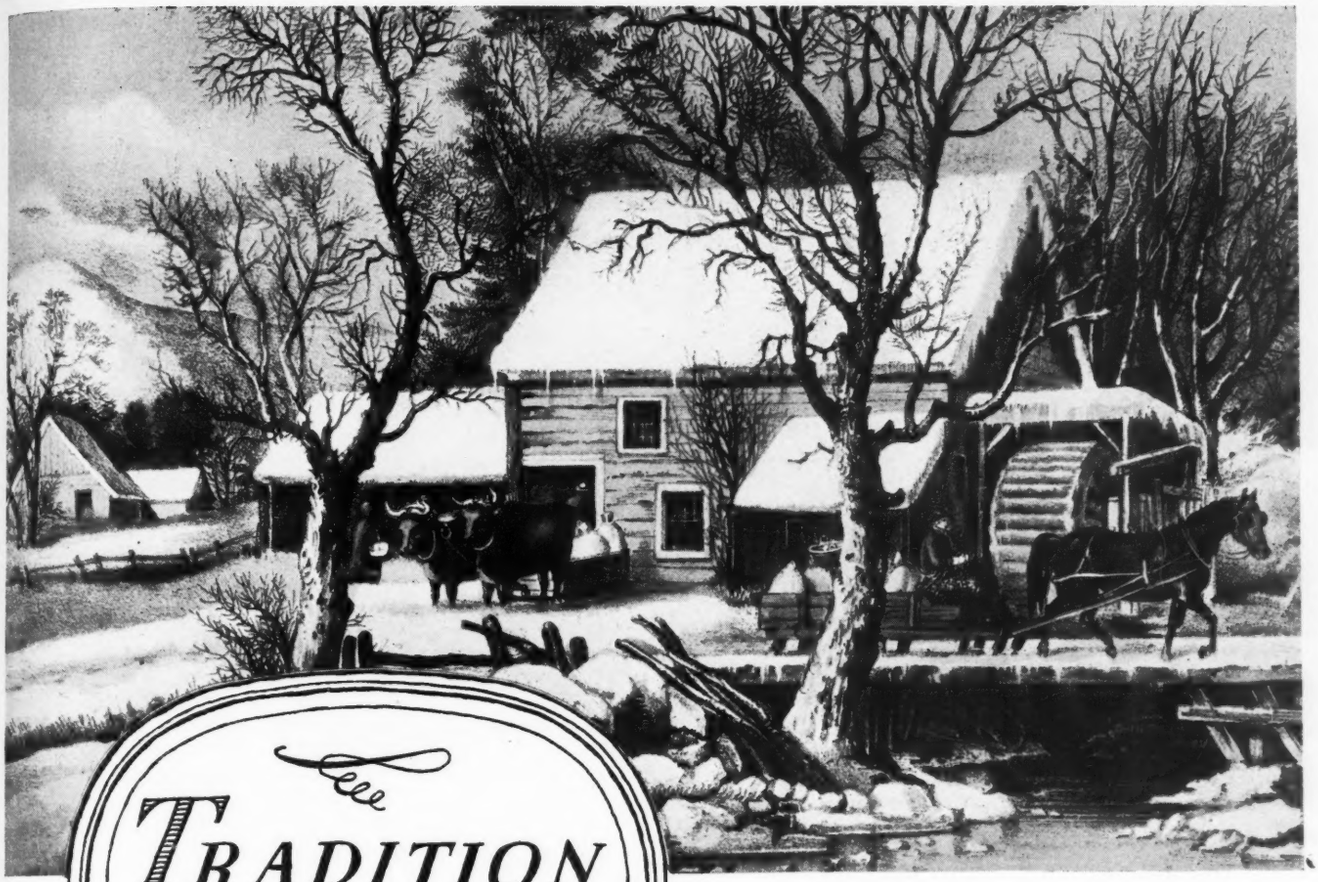
Having finished payment on June 1 on an $8,000 note, which cleared its entire indebtedness, the Community Hospital of Kane, Pa., has purchased new equipment and furniture, according to Mrs. Helen B. Ross, R.N., superintendent. Items recently purchased include new beds, a refrigerator, surgical instruments, gastro-evacuator, a hemaglobinometer, dark field illuminator, cassettes for the x-ray department, typewriter, and chromium furniture for the waiting room.

Trailer Hospital Planned

A hospital on wheels will be added to San Francisco's public health service, if plans of Dr. J. C. Geiger, city health officer, are approved by the board of supervisors. The hospital would include a trailer to an ambulance, completely equipped for emergency work with an operating table, two beds, surgical instruments and all other modern aids.

Name Ward for Doctor Jackson

Dr. Chevalier Jackson, prominent Philadelphia ear, nose and throat specialist, has been honored by having a ward named for him in the Paris Children's Hospital.



TRADITION LIVES ON

Christmas more than any other season reminds us of the enduring power and ageless beauty possessed by certain of our traditions. In the Eighties, the farmer's family gave rapt attention as he read aloud from Dickens' "Christmas Carol." Today, as his grandson twists a radio dial, poor old Scrooge and little Tiny Tim live again. From printed page to air waves — the story is still a part of Christmas Day.

Those who foresee only a dark future for their community hospitals overlook the enduring strength of tradition. Public support of these hospitals — before and beyond other "charitable enterprises" — is a permanent part of American life.

That fact has been demonstrated for eighteen years by the consistent success of our specialized hospital campaigns. And in recent months, oversubscription of large building funds has given fresh proof that the American tradition of supporting voluntary hospitals is living on.

Consultation with your Board or Committee will be arranged without obligation.

In our last four hospital campaigns concluded this fall, $2,050,000 was sought and $2,118,000 (103%) was obtained.

With our direction and services, Ellis Hospital, in Schenectady, sought a $700,000 building fund. The campaign closed November 8 with $850,000.

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NAMES IN THE NEWS...

Administrators

ALBERT W. BUCK, administrator of the New Haven Hospital, New Haven, Conn., has resigned to accept a similar position at the Charlotte Hungerford Hospital, Torrington, Conn. Mr. Buck succeeds DR. ALLAN CRAIG, who recently became administrator of the Eastern Maine General Hospital, Bangor, Me.

William A. Hacker

WILLIAM A. HACKER, acting superintendent of McKeesport Hospital, McKeesport, Pa., who has been connected with the institution for more than sixteen years, recently was named superintendent. Mr. Hacker succeeds WILLIAM H. COX, who resigned because of ill health. Mr. Cox, superintendent of the hospital since 1929, recently has been on an extended leave of absence. The new superintendent became connected with the hospital at the age of seventeen years when he was given a job in the hospital office as stenographer and bookkeeper. Five years ago he was appointed assistant superintendent, and in April of this year assumed the position of acting superintendent.

SYDNEY J. BARNES has been appointed superintendent of the Holyoke Hospital, Holyoke, Mass., succeeding AMY E. BIRGE. Mr. Barnes formerly was administrator of the United Hospital, Port Chester, N. Y.

SAMUEL G. ASCHER, who has been superintendent of the Beth David Hospital, New York City, for more than four years, has received the title of "executive director" through recent action of the board of trustees. The title was bestowed upon Mr. Ascher in recognition of his efforts in equipping the new ten-story fireproof hospital building, dedicated in October. The hospital is thoroughly equipped with the most modern scientific apparatus that goes toward the proper care in a general hospital.

DR. STEPHEN MANHEIMER has resigned his post as executive director of the Jewish Hospital of Brooklyn, N. Y., effective December 1, to accept the appointment of director of Mount Sinai Hospital, Chicago.

DR. MORRIS HINENBURG has resigned as medical director and superintendent of the Sanatorium of the Jewish Consumptives' Relief Society, Spivak, Colo., and resumed his former position as executive director of the Jewish Hospital of Brooklyn, N. Y., on December 1. Doctor Hinenburg was assistant director of Montefiore Hospital, New York City, for more than seven years.

JAMES A. HERNDON, Columbia, S. C., has been elected superintendent of the new Dorchester County Hospital, Summerville, S. C. Mr. Herndon has been connected with the supply department of the Veterans' Administration Facility, Columbia, S. C., for the last five years.

FLORA SMITH, Indianapolis, Ind., has been employed as superintendent of the Lawrence County General Hospital, Ironton, Ohio. Miss Smith succeeds ANNA LAUMAN of Harrisburg, Pa., who has held that position since the opening of the new hospital in September.

LIEUT. JAMES SCHREIDER, formerly of the U. S. Navy, has been appointed superintendent of Riverview Hospital, Red Bank, N. J., succeeding ELEANOR C. TILTON, who resigned during September to accept a position at Perth Amboy General Hospital, Perth Amboy, N. J.

DR. A. R. SCHIER has resigned as superintendent of the Iowa Hospital for Epileptics and School for Feeble-Minded at Woodward. He has been succeeded by DR. CHARLES E. IRWIN of Marshalltown.

A. L. BRODIE, chief clerk in the state auditor's office at Springfield, Ill., has resigned that post to become superintendent of the Frances E. Willard Hospital, Chicago. Mr. Brodie formerly was chief clerk in the Chicago coroner's office.

DR. GEORGE ALFRED DODDS, San Haven, has been appointed superintendent of the North Dakota State Tuberculosis Sanatorium at San Haven for a two-year term to succeed DR. CHARLES MACLACHLAN.

DR. FORREST C. TYSON, superintendent of the Augusta State Hospital, Augusta, Me., has been named Maine state chairman of Tufts College Medical School's $2,000,000 campaign for a new building to be located in downtown Boston.

ELIZABETH GALLERY, R.N., has been elected superintendent of the Greene County Memorial Hospital, Waynesburg, Pa. Miss Gallery formerly was assistant superintendent of the Greenville Hospital, Greenville, Pa. She is a graduate of the University of Pennsylvania Hospital.

DR. JOSEPH A. CAMPBELL, managing officer of the East Moline State Hospital, East Moline, Ill., has been appointed acting head of the Anna State Hospital, Anna, Ill., pending appointment of a successor to the late DR. RALPH A. GOODNER.

A. D. KINCAID, JR., business manager of the Cabarrus County Hospital, Concord, N. C., has submitted his resignation, effective January 1, to become assistant superintendent of the City Memorial Hospital, Winston-Salem, N. C.

ALEXANDER B. RANDALL has been appointed administrator of St. Luke's and Children's Hospital, Philadelphia. Mr. Randall is a graduate of the University of Pennsylvania in civil engineering. He enters the field of hospital administration with experience in economic and financial research in construction engineering, having been associated successively in several important projects in Philadelphia, with the Regional Plan Association of New York, the State Housing Authority of New Jersey and the federal division of Economic Research and Planning.

MAUD L. EWING has resigned as superintendent of the King's Daughters' Hospital, Martinsburg, W. Va.

DR. RAY J. GARVEY, consultant to DR. J. NORMAN WHITE on the surgical staff of Moses Taylor Hospital, Scranton, Pa., has been named director of the Scranton Private Hospital, succeeding the late DR. CHARLES E. THOMSON.

DR. ALEXANDER F. FRASER of San Francisco has been appointed assistant superintendent of the Sonoma County Hospital, Santa Rosa, Calif. Doctor Fraser has been on the medical staff of the Alameda County Hospital, Tulare County General Hospital and the Fairmont Hospital.

DR. HARRY J. WORTHING, superintendent of Willard State Hospital, Willard, N. Y., was transferred to the Pilgrim State Hospital, Brentwood, Long Island, N. Y., on December 1. He succeeds DR. KENNETH KEILL, who has been acting superintendent since DR. WILLIAM J. TIFFANY was appointed commissioner of mental hygiene in October. Doctor Worthing has been superintendent of Willard State Hospital since Jan. 1, 1935. He previously was first assistant physician at St. Lawrence State Hospital, Ogdensburg, N. Y.

KATHERINE HENNESSEY, R.N., head of the surgical department of the Stouder Memorial Hospital, Troy, Ohio, has been elected superintendent of the hospital succeeding EDITH MARTIN, who resigned.

NINA BETHEA CRAFT, R.N., is the head of the new Tidewater Victory Memorial Hospital, recently completed at Norfolk, Va.

MRS. LEONARD NICHOLSON, for the last fourteen years superintendent of the San Fernando Hospital, San Fernando, Calif., has announced her resignation. She is succeeded by MRS. HELEN SAUNDERS, R.N.

NAOMI ZITTROUER, superintendent of the Brooks County Hospital, Quitman, Ga., has been named superintendent of the Bulloch County Hospital, Statesboro, Ga.

MRS. GELA HARMON SCHULTE has resigned as superintendent of the Riverside Hospital, Paducah, Ky., the resignation to become effective December 31.

DR. HENRY J. HOYE, Providence, R. I., succeeds DR. WARREN SANBORN as superintendent of the Rhode Island State Home and School. Doctor Hoye formerly was on the surgical staff of Rhode Island Hospital, advancing to the position of visiting surgeon in which capacity he has served for seventeen years. He is now consulting physician on the staff of that hospital.

LOUISE SANFORD, who has been acting superintendent of Addison Gilbert Hospital, Gloucester, Mass., since the retirement on August 1 of MARTHA JANE AVARD, has been named superintendent.

A. K. FULKERSON has been appointed superintendent of the Day-Kimball Hospital, Putnam, Conn., filling the post vacated by NELLIE L. BLOXHAM. Mr. Fulkerson has been business manager of the hospital for three years, and acting superintendent since Miss Bloxham's retirement a few months ago.

MARY R. OGDEN has resigned as superintendent of Nantucket Cottage Hospital, Nantucket, Mass., and has been succeeded by ADELINE CRAVOTT, for many years supervisor of nurses and technician.

Department Heads

E. JANE HOLDEN has resigned as superintendent of the training school for nurses, Mountainside Hospital, Montclair, N. J.

MARY E. PILLSBURY has been appointed adviser to the school and nursing service of Englewood Hospital, Englewood, N. J.

DR. WILLIAM N. PARKINSON, medical director, Temple University Hospital, Philadelphia, recently was elected vice president of Temple University. Doctor Parkinson has been dean of the university's medical school for the last eight years.

GLADYS I. JOHNSON, R.N., former assistant to the director of nursing service, Grace Hospital, Detroit, is the new director of nursing service at Chicago Memorial Hospital.

MRS. ETHEL M. OWENS, R.N., former superintendent, Greenville Hospital, Greenville, Ohio, has been chosen as director of nursing service for Mountainside Hospital, Montclair, N. J. OLGA DITTIG, R.N., has been appointed director of the school of nursing at the hospital.

MARGARET MCKINLEY has resigned as dietitian at the Evangelical Covenant Hospital, Omaha, Neb., to do further university study.

DR. EUGENE F. CALLANAN, night executive at Boston City Hospital and head of the Dowling Unit, has announced his resignation to enter private practice. DR. THOMAS J. O'BRIEN, heart specialist, and a graduate of Tufts Medical School, will succeed Doctor Callanan as night executive.

DR. ELLIS A. STEPHENS has been appointed to succeed the late DR. A. B. ECKERDT as medical director of the Kaneohe Territorial Hospital, Heeia, T. H.

MARION E. SAWTELLE, former business manager of the board of education, Binghamton, N. Y., has been appointed assistant superintendent of the Binghamton City Hospital.

Miscellaneous

DR. W. R. WILLIAMS, owner of the Mattie Williams Hospital at Richlands, Va., has purchased the Grace Richardson Hospital at Grundy, Va., for $35,000. It is understood the new management will enlarge the hospital.

DOUGLAS W. SVENDSON has been named assistant to the director of the Louisiana state hospital board. He will also continue in his present position as chairman of the board of appeals of the state welfare department and as administrative assistant to the commissioner of public welfare.

STELLA FIIJAN, formerly of Charity Hospital of Louisiana, New Orleans, is the new dietitian at Hastings State Hospital, Ingleside, Neb.

LOUIS I. MATTHEWS has resigned as president and trustee of St. Luke's and Children's Hospital, Philadelphia. He has been succeeded by G. C. KUEMMERLE.

ALICE G. TURNER, former assistant superintendent of the Christie Street Hospital, Toronto, Ont., has been appointed to succeed JEAN MATHESON as matron of Shaughnessy Hospital, Vancouver, B. C.

SYDNEY LAMB, secretary of the Merseyside Hospitals Council, Liverpool, England, has resigned as general secretary and treasurer of the International Hospital Association because of a difference of opinion with the president of the association, DR. G. VON DESCHWANDEN. Doctor Von Deschwanden refused to participate in an open contravention of the Swiss civil law proposed by Mr. Lamb. DR. W. ALTER, honorary president of the association, Buchschlag, Hessen, has been made acting general secretary.

E. N. MEUSER, who has spent twenty years in pharmacy work in China, has returned to the United States and Canada on behalf of the West China Union University, with which he has been connected for a number of years. Mr. Meuser is soliciting Western aid in the construction of a pharmacy building to accommodate the department in an enlarged program for training pharmacists. It will be located in Chengtu, Szechwan.

DR. WILLIAM FREEMAN SNOW, general director of the American Social Hygiene Association and leader in social hygiene and public health education, was the guest of honor recently at a testimonial dinner, attended by more than 400 persons at the Waldorf-Astoria, New York City. The gathering was believed to have been the first large, public dinner ever held to honor a person for work in the eradication of social diseases.

WALTER C. TEAGLE, chairman of the board of the Standard Oil Company of New Jersey, has been named chairman of the industry section in the United Hospital Campaign, it has been announced by CLARENCE FRANCIS, chairman of the commerce and industry committee. Mr. Teagle will organize twenty-six industrial groups to support the appeal for funds for ninety-two voluntary hospitals in New York City and the Visiting Nurse Association of Brooklyn. The campaign will attempt to meet hospital deficits totaling $3,171,134.

Deaths

LUCY LAUMANN. sixty-one, former superintendent of Women's and Children's Hospital, Toledo, Ohio, and at the time of her death surgical supervisor in the Lutheran Hospital, Fort Wayne, Ind., died recently following a heart attack. Miss Laumann was a graduate of the Toledo Hospital School of Nursing.

AMY LINSENMYER, superintendent of the Latrobe Hospital, Latrobe, Pa., for six years, died recently after a week's illness of pneumonia. She was a graduate of the Braddock General Hospital School of Nursing, Braddock, Pa.

MATTIE E. GAST, superintendent of Point Pleasant Hospital, Point Pleasant, N. J., died recently. She had resigned her post at the hospital because of ill health. ARNOLD LANE had been appointed as her successor.

ELIZABETH MACDILL, R.N., who resigned several months ago as superintendent of the Syracuse Memorial Hospital, Syracuse, N. Y., died recently in California. At the time of her resignation, Miss MacDill was succeeded at the hospital by CARL P. WRIGHT.

HANNAH JANE EWIN, superintendent of the Free Hospital for Women in Brookline, Mass., for twenty-three years before she retired in 1929, died recently at Pinehurst, N. C., after a short illness.

HENRY KENDALL MULFORD, director of research and biological laboratories of the National Drug Company since 1926 and president of the Mulford Colloid Laboratory, died recently at the age of seventy-one.

MOTHER MARIE EMMA HAMEL, for the last three years superior of Mercy Hospital, Hempstead, Long Island, N. Y., died suddenly.

LITERATURE *in* ABSTRACT • • •

Conducted by E. M. Bluestone, M.D. and Joe R. Clemmons, M.D.

Infections From Food Handlers

The control of food handlers with communicable diseases was first attempted by the board of health of New York City in 1916. Compulsory annual medical examination was first required in March, 1923, and was discontinued in September, 1934.* Examination and certification was discontinued by the board of health after the following considerations:

1. Examination of food handlers by private physicians cannot be accepted as reliable.

2. If made exclusively by the board of health, the cost of the examinations is not commensurate with public health benefits. A thorough examination would cost about $4 per person, or $1,333,333 annually.

3. Food handlers may become infected soon after examination and certification.

4. Many communicable diseases, such as skin conditions, syphilis, gonorrhe d tuberculosis are not spread by food handlers.

Measures that may be taken to protect the public against infections are:

1. Prompt reporting of communicable diseases, giving the occupation of the individual.

2. Close follow-up of cases of typhoid fever.

3. Exclusion and strict supervision of food-handler typhoid carriers and food-handler members of their families.

4. Education of food handlers in (a) personal hygiene and (b) handling of food.

5. Impressing upon employer and employee alike that they are jointly responsible for violating the law if a food handler with a communicable disease is found employed.

*Best, William H., M.D.: Is Routine Examination and Certification of Food Handlers Worth While? Am. J. Pub. Health (Oct.) 1937. Abstracted by Mildred Willis.

When Color Is Illegal

Color is not used in food preparation in the home except, perhaps, in the coloring of jellies and frostings. Commercially, it is used extensively both legally and illegally. Though it adds no nutritional factor, the addition of color to foods is generally accepted because it appeals to the eye; in many instances colored commercial foods look much like the uncolored home-cooked product.*

To prevent fraudulent use of color in food, laws have been passed, both federal and state. The food colors are usually coal-tar products, though vegetable dyes are used to some extent and are known to be nonpoisonous. Confectionery is colored chiefly to distinguish flavors, but there was a time when brown oxides of iron were used to conceal deficiency of chocolate. Occasionally, partly skimmed or watered milk was colored and the ignorant consumer enjoyed this milk because it looked rich even after being skimmed for the breakfast coffee.

Coloring is permitted in butter but is prohibited in oleomargarine; thus, a more uniform color can be maintained in butter which is subject to seasonal variations, but oleomargarine cannot pass as butter even though made from unbleached oils. Beverages, too, are colored. A most misleading example is orangeade, which is really orange soda, composed of carbonated water, sugar, citric acid, color, a colloidal cloud and a little orange oil.

*Lythgoe, Herman C.: The Coloring of Food: Its Use and Abuse, Scientific Monthly (Aug.) 1937. Abstracted by Helen Lubach.

Check on Quality of Fruits

Dried fruits are divided into two groups: cut fruits — apricots, peaches and pears — and whole fruits such as prunes and raisins. Each type is harvested fully ripe and each is subjected to a more or less standard process.* Before drying, cut fruits are exposed to sulphur fumes and prunes are dipped in a hot lye bath for a few seconds, then rinsed in clean water. When fully dry, the fruit is boxed and sent to packing houses, graded and held in storage until sold, when it is removed from storage and processed, hand-sorted and packed.

The fruit packers who buy the dried fruit from growers, treat it and deliver it to the consumer are now united in a voluntary organization — the Dried Fruit Association of California. This association has organized a technical committee which has appointed committees to offer advice and suggestions to growers as to better and more profitable methods of production, thus eliminating many unfavorable practices. The fig industry enjoys an additional million dollars annually because damage by insects and fungus diseases has been checked; the cut fruit industry has found the minimum sulphur content for the preservation of all the desirable properties of the fruit, reducing the original sulphur content by about 50 per cent; cleanliness and sanitation are under control; regular monthly inspection of all plants has been instituted; fumigation has improved; elimination of poorer grades is being studied; voluntary inspection service has been set up for export and interstate commerce products; research laboratories have brought forth the tenderized prune and prune juice; retailers and wholesalers of the packed fruit are instructed about storage.

*Richert, Walter S.: How a Whole Industry Controls Quality, Food Industries (Oct.) 1937. Abstracted by Helen Lubach.

Quality Control for Poultry

Poultry standardized to a quality level unheard of a few years back is now available, owing to close control and careful processing.*

Quality control begins with selection of birds on the farm. The graded birds are fattened, then killed, bled and the feathers removed. After careful cleaning, the animal heat is removed overnight at a temperature of 32° F. The poultry is then graded according to size and quality. Only first grade birds are selected for freezing. They are then government inspected.

Preparatory to freezing, the head and feet are severed, the birds are eviscerated, thoroughly washed inside and out under high pressure sprays; freed of excess water in a centrifuge; again inspected for cleanliness.

Each carcass is wrapped in transparent cellulose, put into a stockinet, sorted according to size and packed in waxed cardboard cartons. The birds are now ready for freezing in the plate type of freezing unit. The freezing completed, they are packed thirty-six to a box in double corrugated paperboard boxes and kept in storage until shipped.

*Unsigned: Quick-Freezing Quality in Poultry, Food Industries (Oct.) 1937. Abstracted by Rosalyn Siegal.

Compact Pathologic Display

Effective display of preserved pathologic material is essential for the correlation of clinical, gross and histologic aspects of disease* A simple sturdy shelf for exhibition of museum specimens may be made from a 1-inch maple board, ten inches wide and 40 feet long, set up at eye level and supported by heavy steel angle irons. Porcelain enameled steel reflectors placed in a trough at the front edge of the shelf give excellent lighting. A rail allows for adjustment of cards.

This exhibit arrangement is a satisfactory and economical form of presentation if students are instructed to avoid handling the jars.

*Rukstinat, George J.: Laboratory Methods and Technical Notes, Arch. of Path., pp. 366, September, 1937. Abstracted by J. Masur, M.D.

Know Your Man

Intuition in picking people is seldom a God-given second sight. It is usually about 95 per cent shrewd observation.* Hunt out the peculiar requirements of the work, suggests Erwin Haskell Schell, author of "Executive Control."

If you have hired many people you know that the Declaration of Independence was all wrong when it said, "All men are created equal." When selecting personnel the following traits are prime factors and the employee possessing them cannot help but make good: (1) initiative, (2) good memory, (3) education, (4) sense of duty, (5) natural bent, (6) ability to learn, (7) natural intelligence, and (8) stick-to-it-tive-ness.

Purchasing agents need mental curiosity to seek out reasons why one kind of goods will be desirable. They also require good memory, accuracy, scientific trend of mind to run comparison tests, and an open mind that is willing to consider new things.

Ability to learn (coupled with willingness to do so) will carry persons of mediocre ability and experience a long way in any line of business.

Natural bent or aptitude goes a long way toward enabling people of moderate education to develop a high degree of skill at a job. One man takes to a certain kind of work like a duck to water, whereas another does it with great difficulty and constant prodding.

Experience is analyzed critically by skilled employers. If an applicant's record shows that his jobs have grown bigger and that additional responsibility has been placed on his shoulders, it is safe to deduce that the individual can adapt himself or herself to unfamiliar situations and be versatile enough to do more than is required.

The ability to make sound decisions is essential for success. The person who has initiative will carry out instructions without asking a million petty questions about how to do it. He also will have the mental courage to do what is necessary without being afraid to take the consequences.

The desire to learn more than the job calls for makes the difference between filling that job in a routine manner and making a profession of it. It is the quality you will find in the most successful purchasing agents, promotion managers, catering managers and top-notch executives.

Methodical, orderly habits of thinking are indispensable to those who direct the work of others. The executive who gets a lot done without seeming to try hard has this ability.

The success of the head of a large organization is largely due to the fact that each of his department heads feels a great sense of responsibility for doing this particular job well. This success is most prominent where the boss gives his executives the authority to carry through and shows that he has confidence in their ability.

Application blanks are often too sketchy, less information being given than that required by any well-conducted business. An applicant may be able to give satisfactory answers and still be a failure.

*Unsigned, Picking People Who Use Their Heads, Rest. Mgmt., January, 1937. Abstracted by C. E. Croft.

Mental Disease and Tuberculosis

The incidence and relationship of pulmonary tuberculosis to mental disease have been subjects of discussion for many years. Little tangible knowledge, however, has evolved in spite of unanimity of opinion that pulmonary tuberculosis is considerably more frequent in psychiatric institutions than in the general population and that it accounts for many patient deaths.

To the reviewer's knowledge, the study by Dr. Louis Carp represents the first serious attempt to discuss the problem from the point of view of a physician who is engaged in thoracic surgery and the modern treatment of pulmonary tuberculosis.* Doctor Carp's position as member of the board of visitors of Rockland State Hospital explains this seeming paradox. It is another illustration of the phenomenal progress that has been made in the active treatment of pulmonary tuberculosis in the past decade.

The board of visitors of the Rockland State Hospital has been studying most of its patients who, in addition to their mental disease, are suffering from pulmonary tuberculosis.

A questionnaire was sent to the superintendent of each state hospital in an attempt to elicit information on the following questions: (1) number of psychiatric cases; (2) number of cases of tuberculosis; (3) number of cases developing during the year; (4) number of sputum — positive cases; (5) number of cases with unilateral cavitation; (6) number of cases with bilateral cavitation; (7) number of deaths from tuberculosis; (8) type of facilities in each hospital for the modern care of tuberculosis, and (9) special training of each physician and attendant in view of the fact that the treatment of tuberculosis with the most modern methods has become so highly specialized.

An analysis of the data obtained revealed that of a total of about 68,000 patients, approximately 1,600, or 2 per cent, are diagnosed as tuberculous. The mortality rate was 25 per cent, figured in terms of the total number of tuberculous patients. This figure is about twice that obtainable in municipal tuberculosis hospitals in New York City.

As might be expected, it was found that the medical and surgical treatment of tuberculosis in psychiatric patients is not sufficiently aggressive or specialized.

It is recommended that all new admissions and all new employees of psychiatric institutions be carefully examined by clinical, roentgen and laboratory studies to minimize the presence of unrecognized cases of pulmonary tuberculosis and adequately to treat those having the disease. These should be transferred to tuberculosis units established at strategic points throughout the state under the supervision of the department of mental hygiene.

*Carp, Louis, M.D.: The Tuberculosis Problem in New York Civil State Hospitals, Psychiatric Quarterly Supplement 11: 276-282 (July) 1937. Abstracted by Eli H. Rubin, M.D.

Air Conditioning Objectives

The objective of air conditioning is to supply and maintain an atmosphere having a composition, temperature, humidity and motion which will produce desired effects upon occupants or materials in a room.*

Of primary importance is the removal of various harmful substances from the atmosphere. Siliceous and irritating dusts, bacteria, pollen and gases constitute menaces to health and warrant intensive and extensive investigations by public health officers and ventilation engineers. Unidentified substances associated with odors produced by human bodies and organic substances definitely influence comfort and appetite. Air change should be sufficient to eliminate body odors; many variables in any given situation make it difficult to standardize criteria for volume of change, the range being from 7 to 38 cubic feet per minute.

General physical characteristics of the atmosphere regulate heat elimination from the human body. The influence of ionic charges as a practical problem of ventilation is negligible. Sunlight is important from the standpoint of illumination, aid to cleanliness, psychologic stimulus, and ultraviolet effect—all sound hygienic arguments for elimination of the smoke nuisance. Heat loss from the human body is regulated by air temperature, air movement, relative humidity and the sum of the radiation effects of surrounding surfaces. Ventilation research has yielded satisfactory charts of effective temperature for various seasons. However, these studies neglected the factor of influence of radiating surfaces, which is being studied in the Yale laboratories at present.

The author discusses advances in heating and cooling mechanisms. We should not, however, be satisfied merely with avoidance of harmful conditions, but rather increased efficiency and joy of living.

*Winslow, C.-E. A.: Recent Advances in Our Knowledge of the Problems of Air Conditioning, Am. J. Pub. Health, pp. 767, August, 1937. Abstracted by J. Masur, M.D.

BOOKS ON REVIEW

CHRISTIAN R. HOLMES, MAN AND PHYSICIAN. *By Martin H. Fischer, M.D., Springfield, Ill.: Charles C. Thomas.* 1937. *Pp.* 233.

Written by a warm admirer, this book traces the long series of battles that constituted the career of the Danish immigrant who shook Cincinnati out of its "medical mediocrity" and virtually built the Cincinnati General Hospital and the College of Medicine of the University of Cincinnati.

Dr. Christian R. Holmes turned from the drafting room of an engineer's office to the study of medicine under the tutelage of his physician, Dr. Elkanah Williams. He was graduated from Miami College of Medicine and served his internship and residency at Cincinnati Hospital, the institution to which he was bound for the rest of his life.

Holmes was characterized as a man obsessed with three ideas: a new hospital for Cincinnati, a better medical school and a more cultivated medical profession.

The battle for the new hospital began gradually and did not come out into the open until the turn of the century at which time Doctor Holmes was appointed a trustee of the hospital. It was a case of fighting a firmly entrenched political machine which did not want a new hospital and which was in a position to put every conceivable obstacle in the way. In the fall of 1902 the city voted for a bond issue to start the building of the new institution — and in 1911 the first unit was opened.

The second ambition, to have a better medical school, was realized in large part through his own efforts as dean of the combined Ohio-Miami Medical College, which ultimately became the University of Cincinnati's school of medicine. During his years as dean, the new medical school was constructed and the faculty was augmented by men who helped Doctor Holmes achieve his third goal — that of making Cincinnati outstanding in the medical field.

AN INTRODUCTION TO THE SOCIAL STUDIES: *An Elementary Textbook for Professional and Preparatory Groups. By Joseph K. Hart, Ph.D., Associate in Educational Sociology, Teachers College, Columbia University. New York: The Macmillan Company,* 1937. *Pp.* 203. $2

Here is a simple introductory text to guide younger students of various professions in the study of society. The material is presented in a general manner so that it may be applied to various groups by the addition of specific situations.

In a survey of this type only a few of the more elementary pillars in social organization, such as groups, communities, the changing world, cities, social institutions and the family, can be included. The function of this nontechnical book of fifteen chapters is to stimulate observation and discussions by the pupil under the careful guidance of the teacher. Using such a friendly guide along well marked trails into the actual world of social problems, the student becomes conscious of the existing environment and, as a result, desires to make original observation his "tool of social inquiry." At the close of each chapter are simple suggestive problems to provoke first-hand study.

Since the purpose of the book is to "prepare the students to work intelligently and to appreciate the social problems which must be met," no effort is made to stereotype the book by setting down ready-made answers.—PAULINE E. DAVIS.

NEW PRODUCTS • • •

Wardrobe Mistress

Sixteen persons of all shapes and sizes packed into 8 square feet of floor space would seem to give an effect somewhat sardinish. But we are told that the All-Steel-Equip Company of Aurora, Ill., can accomplish this with plenty of elbow room for all. A new steel group locker is the answer to the problem of finding locker and storage space where there is no space, or practically none. Called the Unit-Robe, these lockers are made up of box units 12 inches wide, 12 inches high by 18 inches deep, assembled in two vertical columns of six units, separated from each other but connected across the top by a horizontal section of four units. A coat hanger rod is hung between the two vertical columns directly underneath the horizontal section to accommodate the outer garments of sixteen or more persons.

The component units of the locker can be supplied with padlock attachment, or with practically any type of flat key or locker combination lock. They offer security for small articles of clothing and other personal effects against possible depredations on the part of someone who might covet his neighbor's valuables.

No Vacancies

There's always another one where that came from. We humbly suggest the foregoing inspired thought as the motto of the Lowerator Manufacturer Company, Brooklyn, N. Y., who is responsible for a neat rack for storing and dispensing plates, cups and saucers, hot or cold as desired. The racks function automatically. When the top dish is removed the following one silently pops up to take its place, so that there is always one available in the same place and at the same level. An indicator registers when more plates are required. The rack works, we gather, on a heavy spring. To load it one places a supply of dishes in from the top, pushes them down level with the opening and the rack is ready to operate. The manufacturer is proud to point that the mechanism is not dependent upon electricity or external power.

Electrical heating elements are supplied, however, where it is desirable to warm the plates. The unit is automatically controlled by a fixed thermostat. A snap switch, pilot light and extension are included with the rack and need only to be plugged into the nearest socket.

Auto Show

No ambulance is this but a young hospital on wheels, complete with blanket warming cabinets, medical cabinet and a box that houses an intravenous solution. This latest gift of the automobile industry to the hospital field comes from the Dodge Division of the Chrysler Corporation.

The equipment of the ambulance includes two removable stretchers on the right side of the car body, one on the floor and the other suspended from the ceiling directly above it. On the left side of the body and hinged to the wall is a long attendant seat, which folds up when not in use. This may in an emergency be used as a third stretcher. Space can also be provided so that two or more stretchers can be added. Just in case of a massacre.

At the forward end of the interior is a double partition that serves triply as a space for the blanket warming

cabinet, a housing for the intravenous solution and a space that may be utilized for storing extra supplies. There is also a small, locked compartment for narcotics.

When this ambulance is used on a call, the doctor accompanying it can diagnose the patient's illness right there in the ambulance instead of delaying until arrival at the hospital. Dressing of wounds and treatment of injuries, it is said, can also be done in the ambulance by the light of two dome lamps recessed in the top.

Eggless Baking

The experts gather in an anxious huddle to diagnose the ailments of the hospital exchequer. One symptom on which they all agree is obesity of the food bill. Definitely it must be reduced. But how? Exercise and diet do no good. Very well, an operation is necessary. And so the egg, which is responsible for much of the trouble, is ruthlessly lopped off. Not altogether, of course; we must have eggs. But they are unnecessary these days in the making of such things as waffles, muffins, cookies, cakes and biscuits. It seems rather odd to consider baking without eggs, but it is being done. Fixt Products, 1180 Broadway, New York, see to that. This firm specializes in prepared food mixes that need only the addition of water to be all ready for baking. Very convenient and time saving. And, the Fixt Products affirm, the ready-mixed muffins and cake taste just as good as the old-fashioned variety. They are more than willing to send literature describing the various preparations.

Paging New Literature

Undeclared War on China—If there is anything sadder looking than a cold fried egg, it's a cold fried egg on a cracked plate. In fact, even the greatest delicacy loses a lot of its appeal if the china on which it reposes is dingy. Chinaware really leads an awfully hard life, particularly in an institution in which it undergoes not only washing but, we hope, sterilizing several times a day, to say nothing of being carelessly treated by butter-fingered kitchen help. Therefore, the idea in most purchasing agents' minds is to buy china that can stand up under the constant beating it has to take, and, of course, if resistance can be combined with beauty—so much the better.

The Onondaga Pottery Company of Syracuse, N. Y., has long preached the gospel of strength plus beauty in chinaware, and in an effort to spread the word it has recently issued a new catalogue (a work of art in its own right), which it will be glad to send you.

Olfactory Relief—A problem that has long troubled the minds of many has at last been settled. The question is: do the fish in water make the water fishy, or does the water make the fish fishy? Scientists have decided that the fault lies with the water, not the fish. To whichever school of thought you may belong, you will admit that fish steadfastly insist on smelling fishy, especially when being cooked. So, if your chef has sensitive olfactory nerves and is distressed when he has to cook fish, he will undoubtedly lend a willing ear to the blandishments of the Cleveland Range Company, Cleveland, which offers a compartment steam cooker that, it is said, eliminates unpleasant odors.

Of course, odorless cooking is not the only virtue claimed for the Cleveland Steam-Chef in the brand new catalogue describing it. In many cases, the manufacturer states, steam cooking has an advantage over boiling in preserving the nutritive value, fibrous structure and valuable mineral salts of foods. Another feature stressed is economy, not only to fuel, but also of time and labor. It is said that

smaller quantities of food can be cooked at intervals during the serving periods, thereby avoiding an oversupply.

The Steam-Chef is available in eleven models ranging from 1 to 8 bushels in capacity.

Arabian Nights With Variations — In Bagdad a certain poor man, Ali Baba by name, accidentally stumbled on Robber Abou Hassan's cave, wherein was stored treasure accumulated from raids upon passing caravans. The mouth of the cave was sealed by a great rock which rolled away at the sound of the magic words, "Open Sesame." Having made this discovery, Ali Baba promptly availed himself of the knowledge to enter the cave in the robbers' absence and carry away quantities of the loot. However, he was a man of foresight and anticipated the danger of getting caught in the cave and being unable to get out. Suppose, thought he, my memory were to fail me; or suppose the magic words were changed. Should that happen while I am in the cave, it would be very unpleasant, for Abou Hassan is a man of notoriously hasty temper and would not be likely to listen to reason. Truly some way must be found to open the door without the mystic formula.

So Ali Baba pondered long and finally devised the ingenious contrivance known today as the photo-electric cell. Thereafter he made free of the robbers' cave whenever the fancy seized him and waxed very rich and fat in consequence. Nor was he ever caught.

This tale of the origin of the photo-electric cell may deviate somewhat from the strict truth, but surely the opening and closing of a door by intercepting a beam of light is as magical as Abou Hassan's method.

The Stanley Works, New Britain, Conn., which manufactures the equipment that makes magic doors magic, has recently issued a catalogue that elucidates the workings of the photo-electric cell and points out the advantages to hospitals of doors which the busy, burdened nurse and even invalids in wheel chairs can pass through easily.

Going to Extremities.—We don't want to confuse our similes—but the big idea in Pavaex treatment seems to be to mix brains with your boots. At least so we gather from perusal of a little booklet which has just crossed the editor's disorderly desk from the Taylor Instrument Companies, Rochester, N. Y. On page 3, for example, Taylor tells us that "too much emphasis cannot be placed upon the technique of applying this physical method of treatment." On page 5 he gives a list of contra-indications before he gives the indications. Page 7 starts out with the statement that "it is extremely important that passive vascular exercise therapy be carried out under the personal supervision of a Doctor of Medicine trained in the diagnosis and treatment of these serious clinical problems." Page 9 has three important cautions in large type. Having given us nine pages of warning, Taylor then feels that he "can say a few good words for Florida." So the balance of the pamphlet lists the outstanding Pavaex boot features. They do sound very convincing to us.

Shelving the Safety Net — Is there anyone, we wonder, even in this hardened world, whose heart doesn't do a tap dance on his floating ribs at the sight of a window-washer dangling nonchalantly out of a thirty-second story window. For those who frankly confess to getting a cold chill at the thought of washing the outside of a window, we suggest a glance into the pamphlet issued by Richey, Browne and Donald, Inc., 52-15 Flushing Avenue, Maspeth, N. Y. The theme of this pamphlet is the Browne window, otherwise known as the safety window, which it is possible to wash from the inside with the feet planted firmly on the floor—instead of thin air. Besides safety other features mentioned are quietness and controlled ventilation.

SAVED WITH QUADRO

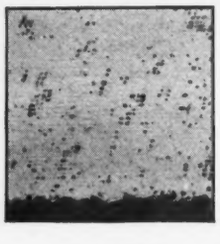
25% PLASTER THROWN AWAY

Don't let water carry away one-quarter of your plaster. Curity QUADRO BANDAGES *save plaster and time.*

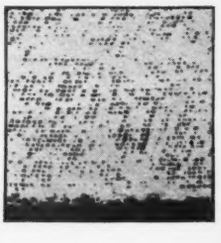
LABORATORY tests prove that 25% of the plaster is left in the water when ordinary bandages are immersed and taken out. Waste is excusable when it is unavoidable; but by using Curity Quadro Bandages you deliver *all* the plaster to the cast.

Quadro Bandages are covered with a water-soluble coating. The plaster is sealed in so that all of it is delivered to the cast. Thus 25% fewer bandages are required! Cast-making is greatly speeded, saving valuable time. Furthermore, tests show that with the Quadro Bandage technique greater cast strength is obtained. These tests bear out the clinical experience of many hospitals that Curity Quadro Bandages are not only the most economical but also the most effective made. They are easy to handle and they require "no wringing out" and they "do not telescope." Let your staff make an actual comparison. Write a trial order.

LEWIS MANUFACTURING CO.
Division of THE KENDALL COMPANY, *Walpole, Mass.*



QUADRO



HOSPITAL-MADE

***QUADRO** and "loose-plaster" bandages were immersed, carefully removed, and photographed. . . . The photomicrographs above show clearly the greater "wet-plaster load" of the* **QUADRO** *Bandage — by laboratory test, 25% more plaster delivered to the cast.*

Curity QUADRO BANDAGES
REG U.S. PAT OFF.

Terms 10 cents a word—minimum charge $2.50. No charge for address or "key" number. 5% discount for cash with order and 10% for two or more consecutive insertions without changes of copy. Forms close 15th of month.

POSITIONS WANTED

ADMINISTRATOR—Graduate nurse with successful record in hospital administration desires appointment; has held every honor which could be conferred upon her; trained and educated in East; six years' experience as assistant superintendent under nationally known administrator; seven years, in charge of fairly large hospital. No. 240, Medical Bureau, Pittsfield Building, Chicago.

ADMINISTRATOR (OR ASSISTANT)—Thoroughly experienced in business and hospital administration; attended hospital administration courses; Protestant; married; locate in any state; best of references. Address M. I. 306, The MODERN HOSPITAL, 919 N. Michigan Ave., Chicago.

ADMINISTRATOR—Young physician who has had four years' experience as assistant superintendent, 400-bed hospital; A.B., M.D., Eastern school; hospital training consists of usual internship and two-year residency. No. 244, Medical Bureau, Pittsfield Building, Chicago.

DIETITIAN—B.S. degree, state university; graduate work, Columbia and University of Chicago; eight years' experience; past three years, chief dietitian, 250-bed hospital. No. 241, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—A.B., M.A. degrees; graduate of Eastern training school; year of graduate work in nursing school administration, Columbia; experience consists of fourteen years' association with two teaching institutions, during eight years of which she served as director of school. No. 243, Medical Bureau, Pittsfield Building, Chicago.

HOUSEKEEPER—Executive experience; ten years full control all housekeeping, laundry, linen, nurses home, personnel. Address M. I. 304, The MODERN HOSPITAL, 919 N. Michigan Ave., Chicago.

PATHOLOGIST—M.D. with Ph.D. in bacteriology; seven years' experience as laboratory director; Protestant; American; married. Address M. I. 302, The MODERN HOSPITAL, 919 N. Michigan Ave., Chicago.

SUPERINTENDENT—Position in private hospital, sanatorium or home for children desired by graduate nurse; 13 years' experience as successful administrator; excellent credentials. Address M. H. 300, The MODERN HOSPITAL, 919 N. Michigan Ave., Chicago.

TECHNICIAN—Registered; B.S., M.S., state university; splendid training in all laboratory procedures, including allergy and intradermal tests; nine years' experience. No. 242, Medical Bureau, Pittsfield Building, Chicago.

MEET THEM HERE—Well established hospitals in the East, South, West and North, in small towns and in large cities are in search of competent employees; they use these columns as a meeting place; tell them your qualifications for the job they have open.

POSITIONS OPEN

ADMINISTRATOR—Physician thoroughly qualified in hospital administration; one of country's leading hospitals; patients average about 500. No. 251, Medical Bureau, Pittsfield Building, Chicago.

ADMISSION OFFICER—Duties consist admitting all patients, house and dispensary; out-patient department averages 85 patients daily; children's hospital; pediatric training desirable. No. 257, Medical Bureau, Pittsfield Building, Chicago.

ANESTHETIST—Willing to combine duties with those of assistant superintendent; small hospital; graduate staff, no teaching; New England. No. 270, Medical Bureau, Pittsfield Building, Chicago.

ANESTHETIST—Two for one of leading hospitals in Chicago area; salaries, $100, maintenance. No. 271, Medical Bureau, Pittsfield Building, Chicago.

ANESTHETIST—Combined record librarian, private Middlewest hospital, 40-beds, mostly surgical cases; $100, maintenance. No. 295 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

ANESTHETIST—For 350-bed county hospital in Central California; $165, meals. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

ANESTHETIST—For small private hospital doing major surgery; someone willing to help in surgery and patient care; San Francisco, $100, meals and laundry. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

ANESTHETIST—250-bed Southern hospital; special training and experience necessary; Roman Catholic preferred. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

ANESTHETIST—(a) Graduate nurse with experience; 200-bed Pennsylvania hospital; salary depending upon experience. (b) 125-bed Ohio hospital. (c) 150-bed Illinois hospital. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

ANESTHETIST—Large psychiatric hospital, New Jersey; salary $110, maintenance. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

ANESTHETISTS—(a) 115-bed general hospital, Wisconsin, two anesthetists employed who alternate; comfortable quarters, $100. (b) 135-bed children's hospital, large city, Pacific Coast, $100, maintenance. (c) 40-bed Catholic hospital, Kansas, $100, maintenance. (d) 60-bed county hospital, Rocky Mountain territory, $115, maintenance. (e) 20-bed hospital, Mississippi, $100, maintenance. Phelps Occupational Bureaus, Denver, Colo.

ANESTHETISTS—(a) Hospital, New Jersey, close proximity to New York, excellent living, salary $80 a month; opportunity for beginner in field. (b) Private hospital, New York City, busy service, salary $100 with maintenance, Protestant required. (c) New York City, semi-private hospital, active hospital, salary $100 with maintenance. (d) Semi-private hospital, upper New York State, active service, salary $100 with maintenance. (e) 250-bed hospital, Connecticut, active service, $125 a month. Nursing Bureau of Manhattan and Bronx, 149 E. 40th St., New York.

ANESTHETISTS—(a) 25-30 years of age, full charge of operating room, $75-$100 with maintenance, Louisiana. (b) Obstetrical supervisor-anesthetist, $85 with maintenance, Kansas. (c) $100 with maintenance, combine with record work, must know typing, Michigan. (d) $90-$100, Eastern hospital. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

ANESTHETISTS—(a) 100-beds, Midwest, active service, two full time anesthetists, $90, maintenance. (b) Combined with record work, 40 beds, eight-hour day, desirable location, $100, maintenance. (c) 85 beds, East, $100, maintenance. (d) Small Southern hospital willing to pay $100 maintenance if combined with general duty nursing. North's Hospital Registry, 408 Republic Bldg., Louisville, Ky.

ASSISTANT DIRECTORS—(a) 225-bed hospital in Middlewest; some college and supervisory experience required. (b) 125-bed Eastern hospital. (c) Children's hospital in East. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

ASSISTANT DIRECTOR OF NURSES—Children's hospital; training and experience in pediatrics required. No. 256, Medical Bureau, Pittsfield Building, Chicago.

ASSISTANT MEDICAL DIRECTOR—Graduate grade A medical school, with hospital administrative experience; large Midwestern hospital; excellent salary and living conditions. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

ASSISTANT SUPERINTENDENT OF NURSES—Duties include teaching medical and surgical nursing; fairly large municipal hospital; Southern metropolis. No. 255, Medical Bureau, Pittsfield Building, Chicago.

ASSISTANT TO SUPERINTENDENT OF NURSES—150-bed hospital; New England; training school; instruct practical arts; salary open. The New York Medical Exchange, 489 Fifth Ave., New York.

See also pages 140-142-144-146 and 148 for other want advertisements

POSITIONS OPEN—Continued

ASSISTANT SUPERINTENDENTS—(a) N. Y. R.N., experience in anesthesia; new 50-bed hospital; within easy reach of New York City; salary $110 and maintenance. (b) Small hospital; New Hampshire; combine duties with anesthesia. Salary $100 and maintenance. The New York Medical Exchange, 489 Fifth Ave., New York.

CHIEF ANESTHETIST—Will work under direct medical supervision; ample number of assistants; operations average 400 monthly; thoroughly qualified woman required; salary commensurate with experience. No. 269, Medical Bureau, Pittsfield Building, Chicago.

DIETITIAN—110-bed general hospital, 40-bed addition under construction; B.S. degree and teaching experience required; starting salary $100, maintenance. No. 296 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

DIETITIAN—50-bed general hospital, Nebraska, $75, maintenance. Phelps Occupational Bureaus, Denver, Colo.

DIETITIANS—(a) 100-beds, Southwest, salary open. (b) 75 beds, children's hospital, combined with housekeeping, good salary. (c) 75 beds, Kentucky, beginning $90, increased to $100 if services satisfactory. North's Hospital Registry, 408 Republic Bldg., Louisville, Ky.

DIETITIAN-HOUSEKEEPER—(Combined) 80-bed children's hospital, South; no teaching; qualified to purchase supplies; sufficient employees; salary $105, maintenance, one month's vacation with salary. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

DIRECTOR OF NURSES—Teaching hospital affiliated with university school of medicine; 100 students; West. No. 280, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—Eastern hospital, averaging 200 patients; 80 students; most desirable location; Eastern candidate preferred; salary sufficient to secure best-qualified woman available. No. 281, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—Postgraduate course in obstetrics, college education or its equivalent required, Protestant, not over 40 years of age, $125-$150 with maintenance, Middlewest. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

DIRECTOR OF NURSES—Recently remodeled and modernly equipped hospital; 125 beds, principally surgical and medical; school averages fifty students; staff includes educational director and instructor; delightful location. No. 245, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—One of country's important hospitals; graduate school only; outstanding woman required; no undergraduate staff. No. 246, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—Maternity hospital; teaching and executive ability in public health point of view essential; college training with graduate training in obstetrics required; $150, maintenance. No. 247, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—Teaching division; state hospital; $125, maintenance. No. 248, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—New privately-owned institution treating pulmonary tuberculosis only; $150, maintenance, including private suite; special training in tuberculosis nursing required. No. 249, Medical Bureau, Pittsfield Building, Chicago.

DIRECTOR OF NURSES—(a) 50-bed hospital, New England State, small school of high standing, accredited. (b) 75-bed hospital, New England State, excellent school, experience and college preparation necessary. (c) 700-bed institution, vicinity of New York City, excellent opportunity for woman of experience and preparation. (d) 300-bed hospital, California, applicants must have experience, college preparation, Protestant, and no personality difficulties. (e) 500-bed hospital, Eastern seaboard state, college degree, experience. (f) 250-bed hospital, close proximity to New York City, the highest qualifications necessary. (g) A post in the Near East for woman 35 to 40 years, Protestant, college and organization ability necessary. Nursing Bureau of Manhattan and Bronx, 149 E. 40th St., New York.

DIRECTOR OF NURSES—Research hospital for study of tropical diseases; conducted under university auspices; seaport town situated in Islands. No. 250, Medical Bureau, Pittsfield Building, Chicago.

DIRECTORS, SCHOOLS OF NURSING—(a) Small Methodist hospital in North Central States. (b) 110-bed hospital in Middlewest. (c) Large hospital on Atlantic Coast. (d) 600-bed hospital in East. (e) Large Southern hospital. (f) 180-bed Methodist hospital in Middlewest; progressive; degree and administrative experience required. (g) 125-bed Southern Catholic hospital; degree. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

DIRECTRESS OF NURSES—100-bed Western maternity hospital; experience in obstetrical nursing required; affiliated and postgraduate students; salary $150, maintenance. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

DOCTOR—Washington State license. Phelps Occupational Bureaus, Denver, Colo.

GENERAL DUTY—Nights; some laboratory training; 33-bed general hospital, Alaska; $105, maintenance; transportation paid if two year contract signed. No. 298 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

GENERAL DUTY NURSES—Wyoming, $70-$75; Oregon, $60-$70; Colorado, $60-$90; Utah, $75-$85; California, $70-$90; all eight hour schedule. Phelps Occupational Bureaus, Denver, Colo.

GENERAL DUTY—Position in California, Washington, and Oregon; salaries range from $70, maintenance to $115, meals; often two or more vacancies in the same institution; majority are 8-hour duty, all one day off weekly. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

GENERAL DUTY—Openings for alert, capable, young women in educational centers. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

GENERAL DUTY NURSES—(a) One of New England's leading hospitals; pediatric and surgical departments; $90, maintenance. (b) Several; one of the most important hospitals in Western New York; 48-hour week; $70-$75, maintenance. (c) New hospital, caring for psychiatric cases; suburb Eastern city; $85, maintenance. (d) Several; small municipal hospital; surgical and obstetrical departments; $93.50, maintenance; resort town; Midwest. (e) Several; tuberculosis and acute communicable disease departments; large municipal hospital; 40-hour week; $90, maintenance. (f) Several; fairly large hospital; 8-hour day, 6 day week; $80, board; California. (g) Several; one of Florida's leading hospitals; $65, maintenance. No. 273, Medical Bureau, Pittsfield Building, Chicago.

GENERAL DUTY—Graduate nurses; 8-hour duty; general hospitals, mental and nervous institutions, and tuberculosis sanatoriums; salaries $65-$75, and maintenance; location: New York, Ohio, Pennsylvania, New Jersey, New England States, Michigan, Illinois, Missouri, also Southern and Western states. Interstate Physicians and Hospital Bureau, 332 Bulkley Building, Cleveland.

GRADUATE NURSE—Take charge of surgery, supervise 12-bed private hospital, buying; $120, maintenance; San Joaquin Valley, California. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

See also pages 139-142-144-146 and 148 for other want advertisements

POSITIONS OPEN—Continued

HEAD NURSE—New 188-bed tuberculosis sanatorium in islands; must be experienced in tuberculosis nursing and supervision; salary, $175, maintenance. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

INSTRUCTOR OF NURSES—(a) 150-bed Michigan hospital; practical instructor employed; salary $120, maintenance. (b) 125-bed Pennsylvania hospital. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

INSTRUCTOR—THEORY—Teaching experience; 150-bed hospital, large city in Ohio; educational advantages; excellent class rooms; open January first. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

INSTRUCTOR—Science, with some preparation; 240-bed Eastern hospital; $120, maintenance, No. 297 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

INSTRUCTOR—Instructor of theory and practice. Nursing Bureau of Manhattan and Bronx, 149 E. 40th St., New York.

INSTRUCTOR—Degree required, 132-bed hospital in Michigan. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

INSTRUCTORS—(a) Science; 35 students; Wisconsin; January 1. (b) Practical; large municipal hospital; $125, maintenance; Midwest. (c) Science; 65 students; immediately; Southern metropolis. (d) Science; 75 students; Northern Indiana; February. (e) Practical; 45 students; college town; South. (f) Science and practical; one of leading hospitals on Pacific Coast; both positions require degrees. No. 268, Medical Bureau, Pittsfield Building, Chicago.

INSTRUCTORS—200-beds South, practical, $100, maintenance. (b) 150 beds South, $115, maintenance. (c) Nursing arts, East, $100, maintenance. North's Hospital Registry, 408 Republic Bldg., Louisville, Ky.

INSTRUCTORS—(a) One of California's outstanding hospitals; University graduate, teaching experience, $175, maintenance. (b) 75-bed Catholic hospital, Montana, $100, maintenance. (c) Science Instructor, 120-bed Catholic hospital, South Dakota, $125, maintenance. (d) 110-bed Catholic hospital, South Dakota, $100, maintenance. (e) Practical and science instructors for 100-bed hospital, Pennsylvania, each $100, maintenance. Phelps Occupational Bureaus, Denver, Colo.

LABORATORY TECHNICIAN-NURSE—(a) 300-bed hospital, California, $135, maintenance. (b) Nurse, laboratory x-ray, 50-bed mining hospital, Utah, $100, maintenance. (c) Nurse-Technician, 50-bed general hospital, Michigan, $115, maintenance. (d) Office Nurse, laboratorian, physical therapist, Ohio clinic, eight hour duty, $130. (e) Laboratory, x-ray technician with bookkeeping, 20-bed hospital, Wyoming, $80, maintenance. Phelps Occupational Bureaus, Denver, Colo.

LABORATORY—X-RAY TECHNICIANS—(a) 115 beds, South, must be capable of taking charge both departments; good living conditions, adequate salary. (b) R.N. Laboratory x-ray technician for large college; to assist with nursing when not busy in laboratory. (c) Florida physician wants R.N. technician; must be quick and efficient, tactful in handling people; $125. (d) Nurse laboratory technician for 50 bed Southern hospital. (e) Several doctors want nurse laboratory-x-ray technicians at good salaries. North's Hospital Registry, 408 Republic Bldg., Louisville, Ky.

NURSE—Surgical; small hospital having college affiliations; young nurse with postgraduate training in surgery; California. No. 272, Medical Bureau, Pittsfield Building, Chicago.

NIGHT SUPERVISOR—(a) University hospital, Rocky Mountain territory, $110, maintenance. (b) 30-bed, Illinois hospital, $90, maintenance. (c) Small Oregon hospital, $75 and maintenance. Phelps Occupational Bureaus, Denver, Colo.

NURSE-TECHNICIANS—(a) Graduate nurse qualified in laboratory work; university health service; $100, complete maintenance. (b) Graduate nurse, well-qualified in laboratory technique; foreign appointment; $160, room, transportation. No. 277, Medical Bureau, Pittsfield Building, Chicago.

OBSTETRICAL SUPERVISOR—Postgraduate in obstetrics; 175-bed hospital, school for nurses; large city, Florida. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

OBSTETRICAL SUPERVISOR—University hospital: $95, meals and laundry. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

OBSTETRICAL SUPERVISOR—298-bed hospital on West coast; charge of 30-bed department; experience necessary. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

OBSTETRICAL SUPERVISOR—P.G. from Chicago Lying-In for large Catholic hospital, California, Catholic preferred, $150, maintenance. Phelps Occupational Bureaus, Denver, Colo.

OBSTETRICAL SUPERVISOR—Post-graduate training, with ability to supervise delivery room and obstetrical floor. 100-bed private hospital; starting salary $85, maintenance. No. 300 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

OBSTETRICAL SUPERVISOR—Able to give anesthesia, Pennsylvania. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

OCCUPATIONAL THERAPIST—One of California's outstanding sanitariums, excellent salary for qualified person. Phelps Occupational Bureaus, Denver, Colo.

OCCUPATIONAL THERAPIST—To direct department; large municipal hospital; good organizer required; $175-$200, including partial maintenance. No. 276, Medical Bureau, Pittsfield Building, Chicago.

OFFICE NURSE—Able meet patients and handle accounts; some ability take x-ray pictures or do laboratory routine, or willing to learn; $100, maintenance; 50-bed private hospital. No. 299 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

OPERATING ROOM NURSE—(a) Small hospital, New Mexico, $85, maintenance. (b) Catholic hospital, Michigan, P.G. Obstetrics required, Catholic preferred. Phelps Occupational Bureaus, Denver, Colo.

OPERATING ROOM SUPERVISOR—125-bed Pennsylvania hospital; active surgical service; experience, qualified to teach student nurses; salary open. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

OPERATING ROOM SUPERVISOR—Postgraduate in operating room technique and executive ability; 175-bed hospital, Central states; 8-hour day, no night calls. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

OPERATING ROOM SUPERVISOR—Post-graduate training and teaching ability, age 28 to 36; 300-bed general hospital; very active surgical service averaging over 400 cases monthly; salary commensurate with preparation and experience. No. 301 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

See also pages 139-140-144-146 and 148 for other want advertisements

POSITIONS OPEN—Continued

OPERATING ROOM SUPERVISOR—50-bed hospital in South; opportunity for advancement. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

PEDIATRIC SUPERVISOR—(a) California hospital, $110-$125. (b) West Virginia hospital, new and modernly equipped, P.G. required, $100, maintenance. Phelps Occupational Bureaus, Denver, Colo.

PEDIATRIC SUPERVISOR—196-bed children's hospital in East; charge of medical floor; good training and experience required. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

PEDIATRIC SUPERVISOR—With experience in pediatrics and postgraduate; 200-bed Pennsylvania hospital; affiliate and postgraduate students. Interstate Physicians & Hospital Bureau, 332 Bulk'ey Building, Cleveland.

PHYSICIAN—Interested to pursue studies of the social and economic problems of medicine as a member of the staff of a national organization; salary $4,000 to $5,000 according to qualifications; state full details of education and experience. Address M. J. 79, The MODERN HOSPITAL, 919 N. Michigan Avenue, Chicago.

PHYSICIANS—(a) Male, Washington State license, $2,400, maintenance. (b) Male, psychiatric experience, Michigan registration required, $1,800, maintenance. (c) Male, eligible for registration, Texas clinic and hospital. Phelps Occupational Bureaus, Denver, Colo.

PHYSIOTHERAPIST—With nursing background; large teaching hospital; East. No 279, Medical Bureau, Pittsfield Building, Chicago.

PHYSIOTHERAPISTS—(a) And x-ray, female, Catholic hospital, Michigan. (b) Registered physictherapy technician, female, Oklahoma hospital. Phelps Occupational Bureaus, Denver, Colo.

PHYSICAL THERAPIST—Eligible membership American Physical Therapy Association; 160-bed private Western hospital; minimum salary $80, maintenance. No. 302 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

PRACTICAL INSTRUCTORS—(a) 150-bed New England hospital; opportunity for administrative experience. (b) 250-bed hospital in Middlewest; degree. (c) Teaching supervisor and practical instructor; large well-known Eastern hospital; excellent opportunity for advancement. (d) 83-bed Western hospital; young woman with degree. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

PRACTICAL INSTRUCTOR AND ASSISTANT DIRECTOR—Qualified person with at least one year's college, including course in principles and practice of nursing; experience preferred; 175-bed hospital, large New England city. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

RECORD LIBRARIAN—Catholic, 21-25 years of age, member National Association of Florida, $75 with maintenance. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

RECORD LIBRARIAN—Qualified in medical dictation; fairly large hospital; Florida. No. 275, Medical Bureau, Pittsfield Building, Chicago.

RECORD LIBRARIAN—Qualified take medical dictation and acquainted with Bellevue nomenclature; 125-bed Seacoast hospital; $75, maintenance. No. 303 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

RECORD LIBRARIAN—(a) Steno, file clerk, New Mexico hospital. (b) Record clerk, Colorado hospital. (c) Registered record librarian, Tennessee hospital. Phelps Occupational Bureaus, Denver, Colo.

SCIENCE INSTRUCTORS—(a) 215-bed hospital on Pacific Coast. (b) 425-bed hospital on Atlantic Coast. (c) 150-bed hospital in East. (d) 550-bed Western hospital; position open January 1st. (e) 250-bed Eastern hospital; vicinity New York City. (f) 113-bed Southern hospital; Roman Catholic preferred. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

SCIENCE INSTRUCTOR—150-bed Lutheran hospital; well equipped teaching unit; college degree; open January first; excellent salary. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SOCIAL WORKER—Medical social worker for one of New Jersey's leading hospitals; must be thoroughly experienced. No. 274, Medical Bureau, Pittsfield Building, Chicago.

SUPERINTENDENT — Privately-owned hospital; small community, largely industrial, located 30 miles from state metropolis; average number of patients 40; $150, maintenance. No. 252, Medical Bureau, Pittsfield Building, Chicago.

SUPERINTENDENT—25-bed Southern hospital, all graduate staff; salary open to experienced executive. No. 304 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

SUPERINTENDENT—(a) Graduate staff; 50-bed hospital, Ohio; desirable salary. (b) 60-bed new Pennsylvania hospital. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SUPERINTENDENTS—(a) Female; 100-bed hospital; Middlewest; five miles from nearest city; Michigan R.N., also experience in T.B. work necessary; salary $1,500 to $1,600. (b) Female; small hospital; Pennsylvania; Pennsylvania R.N.; homeopathic experience; age 40 to 50; salary open. (c) Male; small hospital; New Jersey; experience necessary; salary open. (d) Male; 400-bed hospital; Eastern state; good experience essential; salary open. (e) Male; 200-bed hospital; Eastern state; good experience essential; salary open. (f) Male; 500-bed hospital; New England; good experience necessary; salary open. The New York Medical Exchange, 489 Fifth Ave., New York.

SUPERINTENDENT OF NURSES—50-bed hospital, Kansas City, prefer nurse with P.G. obstetrics and executive ability. Phelps Occupational Bureaus, Denver, Colo.

SUPERINTENDENTS OF NURSES—(a) 250-bed hospital; New Jersey; training school; B.S. degree and experience essential; salary open. (b) 500-bed hospital; New York City; training school; B.S. degree and experience necessary; salary open. (c) Large hospital; Pennsylvania; medical school connections; degree and experience necessary; salary $3,000. The New York Medical Exchange, 489 Fifth Ave., New York.

SUPERINTENDENT OF NURSES—60-bed Western hospital, training school; salary open to experienced director. No. 305 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

SUPERINTENDENT OF NURSES—For medical and surgical services of state hospital; new hospital building; college trained woman required; East. No. 254, Medical Bureau, Pittsfield Building, Chicago.

See also pages 139-140-142-146 and 148 for other want advertisements

POSITIONS OPEN—Continued

SUPERINTENDENT OF NURSES—100-bed Pennsylvania hospital; young woman with college credits and some experience; salary $115. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SUPERINTENDENT OF NURSES—(a) 300-bed hospital, New York City, academic degree, experience. (b) 100-bed near New York City, 35 to 45 years, experience, personable, ability to get along with people. (c) Hospital, psychiatric, 2,000 beds, East, qualified for this field, opportunity for organization and individual expression. (d) Excellent opportunity in South America in hospital sponsored by a known philanthropic organization, 35 to 40 years, experience, Spanish an asset. Nursing Bureau of Manhattan and Bronx, 149 E. 40th St., New York.

SUPERINTENDENT OF NURSES—Fine modern hospital of 175 beds; 65 students; graduate staff of 48; $175; opportunity of advancement to right person; Midwest. No. 253, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—General department; small general hospital; Alaska. No. 258, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Night; must be qualified to take complete charge of institution (185 beds); one night off duty each week; $120, maintenance. No. 259, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Children's department of large teaching institution; ample number of assistants; minimum $115, maintenance. No. 260, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR MEDICAL AND SURGICAL—(a) 350-bed Michigan hospital; salary $100, maintenance. (b) 180-bed Florida hospital. (c) 100-bed Ohio hospital. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SUPERVISORS—Floor and obstetrical supervisor for one of Florida's leading hospitals; former position requires graduate training in ward management; latter, lying-in training; salaries, $95, maintenance. No. 261, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR OPERATING ROOM—Graduate staff; 200-bed New York hospital; salary $125, maintenance. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SUPERVISOR OPERATING ROOM—300-bed Ohio hospital; well equipped surgical unit; ideal living conditions; salary depending upon experience and qualifications. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

SUPERVISORS—Two medical floor supervisors; one for evening duty (2:30 to 11:00), one for day duty; 48-hour week; large teaching hospital, averaging 300 patients; $100, maintenance. No. 262, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Operating room; large teaching hospital now in process of adding beautiful new wing to private patients' building; department consists of 10 splendidly equipped operating rooms; thoroughly experienced woman, capable teaching operating room technique, required; $150, maintenance. No. 263, Medical Bureau, Pittsfield Building, Chicago

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SUPERVISOR—Scarlet fever division averaging 100 patients; graduate nurse staff supplemented by affiliating students; large municipal hospital; executive ability and experience in communicable disease nursing required; $125, maintenance. No. 264, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Psychiatric; new hospital, privately owned, caring for nervous and mental diseases; suburban location; $90, maintenance. No. 265, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Obstetrical and gynecological division averaging 28 patients; will be responsible for two delivery rooms and teaching program; municipal institution averaging 300 patients. No. 266, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—Teaching; tuberculosis department of large municipal group; teaching and tuberculosis nursing experience required; $150, including partial maintenance; West. No. 267, Medical Bureau, Pittsfield Building, Chicago.

SUPERVISOR—(a) Medical floor, able teach medical nursing; 8-hour schedule; 170-bed general hospital, full approved; salary open, depends on training and experience; very desirable. (b) Training and experience in Orthopedics, with ability to handle ward; 50-bed institution, South; salary open. No. 306 Aznoe's Central Registry for Nurses, 30 N. Michigan Ave., Chicago.

SUPERVISORS—Operating Room—(a) 75 beds, South, wants mature, well qualified nurse. (b) 150 beds, Florida, postgraduate, experienced, good salary. (c) 250 beds, Philadelphia, wants splendidly qualified surgical supervisor. Obstetrical—(a) 125 beds, South, postgraduate course, to teach practical nursing. (b) 225 beds, East, wants night Ob. Supervisor, $90, maintenance. Medical—(a) With teaching ability, salary depends on background of individual. North's Hospital Registry, 408 Republic Bldg., Louisville, Ky.

SUPERVISOR—Degree required; opportunity for promotion to instructor; 450-bed hospital, San Francisco region; $135, meals. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

SURGERY—Small California hospital; complete charge department; $135, full maintenance. Business Woman's Registry, 609 S. Grand Ave., Los Angeles.

SURGICAL SUPERVISOR—Large Utah hospital, $100, meals and laundry. Phelps Occupational Bureaus, Denver, Colo.

SUTURE NURSES—Postgraduate in surgery; Midwestern, Eastern and Western states. Interstate Physicians & Hospital Bureau, 332 Bulkley Building, Cleveland.

TEACHING SUPERVISOR—100-bed Midwestern hospital; department of medical and surgical patients. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

TEACHING SUPERVISOR—(a) California hospital, executive ability and experience in tuberculosis nursing and teaching required, $1,600. maintenance. (b) 100-bed, Pennsylvania hospital, degree not essential but experience this type work required, salary open. Phelps Occupational Bureaus, Denver, Colo.

TECHNICIANS—(a) X-ray and laboratory technician; must be capable taking charge in absence of pathologist; x-ray work secondary; well-equipped hospital beautifully located in mountains; Eastern state; quite close to several large cities. (b) Laboratory technician qualified in secretarial work; should be able to run basals and take electrocardiograms; exclusive private club; South; exceptionally attractive surroundings; $100, maintenance. No. 278, Medical Bureau, Pittsfield Building, Chicago.

TECHNICIANS—(a) Laboratory and x-ray; able to type, small hospital, Michigan, $75 with maintenance. (b) Laboratory technician, Florida hospital. (c) Laboratory and x-ray, small hospital, Middlewest. Zinser Personnel Service, 1546 Marquette Bldg., Chicago.

See also pages 139-140-142-144 and 148 for other want advertisements

POSITIONS OPEN—Continued

X-RAY AND LABORATORY TECHNICIAN—57-bed hospital in Midwest; R.N. or A.B. degree required. Nurse Placement Service, 8 S. Michigan Ave., Chicago.

X-RAY TECHNICIAN AND REGISTERED NURSE—Large New Jersey hospital, $90, maintenance. Phelps Occupational Bureaus, Denver, Colo.

PLACEMENT BUREAUS

AMERICAN HOSPITAL BUREAU (Agency)
1825 Empire State Building
New York City

C. M. POWELL, R.N., Director.

Desirable positions open in New York, New England, South and Midwest, for anesthetists; instructors; supervisors (day, night, operating room, obstetrics, general wards); Suture and General Duty Nurses. Many eight-hour duty with good salaries for qualified applicants.

We charge no registration fee. Our placement fee is 25 per cent of the first month's salary for permanent position or 5 per cent of the salary received, for positions of three months or less.

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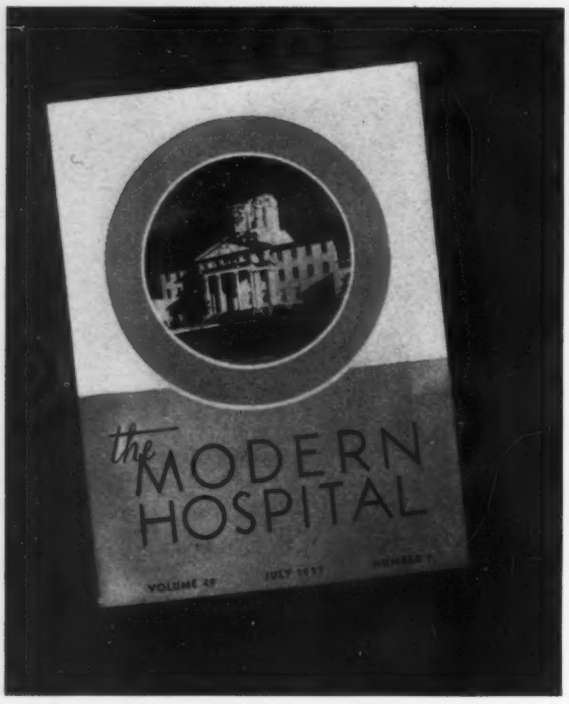

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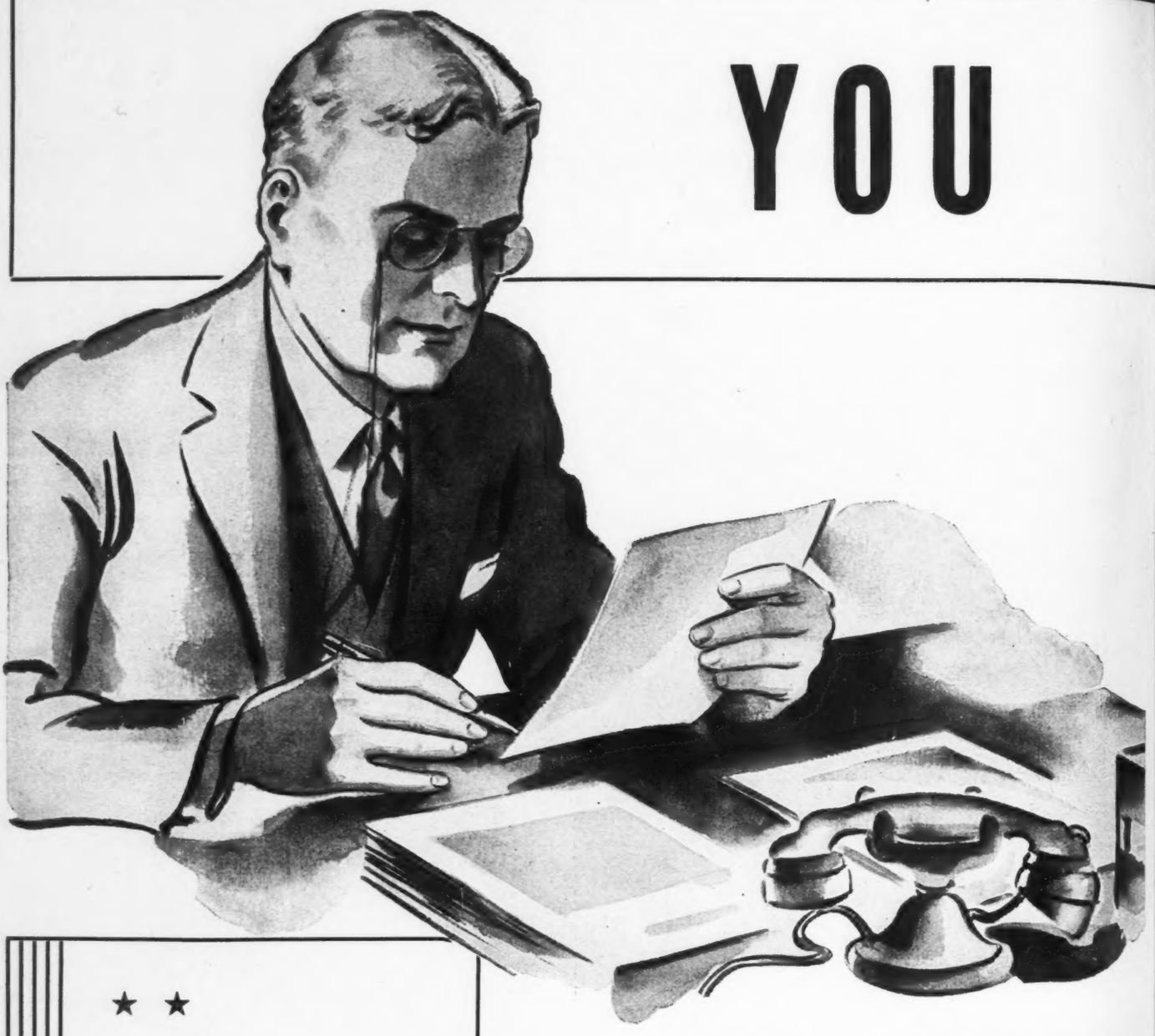

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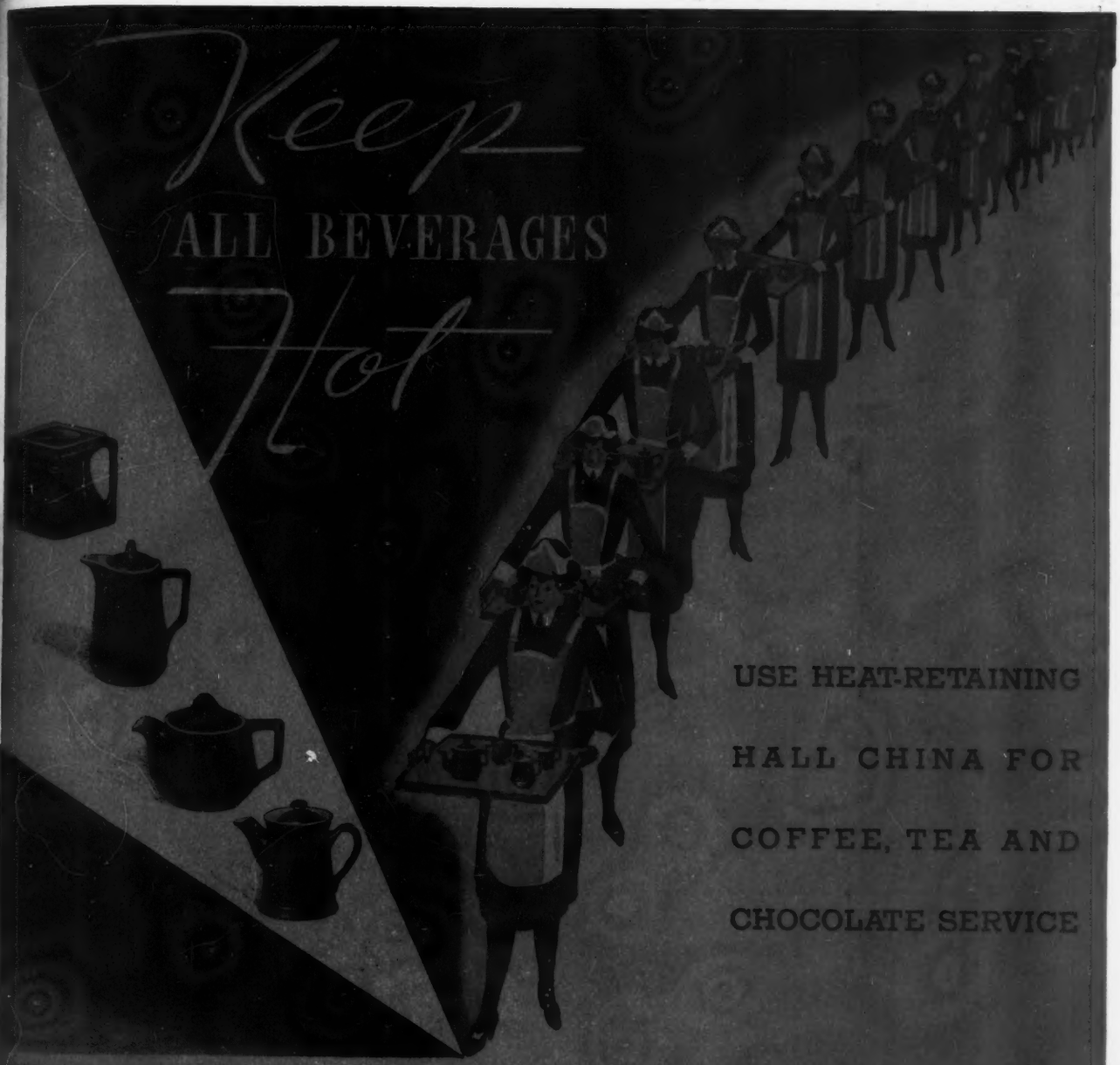

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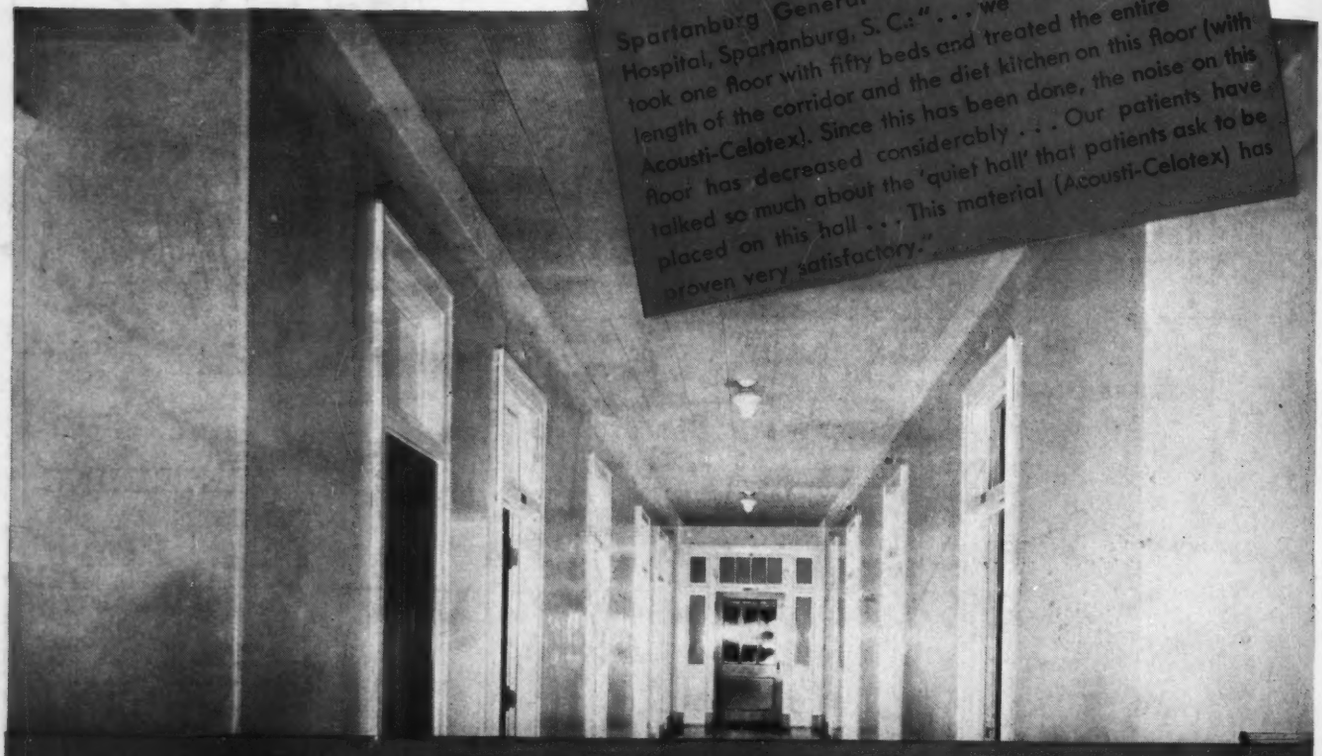

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